

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 4 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64632

S

Local Registrar's No. 18

County of Kootenai

Registration District No. 30

City of Coeur D'Alene

Primary Registration District No. 1051

(No. Home Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Christason

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan. 23, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur D'Alene
(State or country) Idaho

10 NAME OF FATHER C. J. Christason

11 BIRTHPLACE OF FATHER (city or town) Norway
(State or country)

12 MAIDEN NAME OF MOTHER Delphine M. Goulet

13 BIRTHPLACE OF MOTHER (city or town) Minn.
(State or country)

14 Informant C. J. Christason
(Address) Coeur D'Alene, Ida.

15 Filed Jan 26, 1929 A.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 23, 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born infant from leukaemia in mother.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Christason, M.D.

1125, 1929 (Address) Coeur D'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
St. Thomas Cemetery Jan 25, 1929

20. Undertaker Address
Mooney Mortuary Coeur D'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. ~~State cause for which surgical operation was undertaken.~~ For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

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RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64800

S

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. 1908 N. 13th Street.)

Local Registrar's No. 56

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Louise Reed.(a) Residence No. 1908 N. 13th St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 15th 1929

7. AGE Years Months Days If LESS than 1 day, min.
0 0 0 hrs or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

Robert D. Reed.11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Santa Cruz, Cal.

12. MAIDEN NAME OF MOTHER

Mary H. Smoot.13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Silver City, Idaho.14. Informant Mrs. Joe Lawler.

(Address)

Boise, Idaho.15. Filed 2-18-291929Paula M. Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 15th 1929

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw him alive on, 19

and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

2/16/29(Address) Boise, Idaho.

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery. 2/16/29 19

20. Undertaker

Wm. McBratney.Address Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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RECEIVED APR 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **65291** **S**

PLACE OF DEATH

County of **Canyon**City of **Nampa**Registration District No. **1**Primary Registration District No. **106**(No. **Mercy Hospital**)Local Registrar's No. **5**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Mr and Mrs E.M.Clark

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **March 29, 1929**

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Nampa, Idaho**
(State or country)

10. NAME OF FATHER **E.M.Clark**

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) **Kansas**

12. MAIDEN NAME OF MOTHER **Louise Shephard**

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) **Idaho**

14. Informant **E.M.Clark**
(Address) **Nampa Ida.**

15. Filed **4-1**, 19**29** **Edna Conway**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **March 29 1929**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to **Mar 29**, 19**29**
that I last saw ~~him~~ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born. Death occurred several days before birth (Cause undetermined)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) **V E Bullen** M. D.
3/30/29, 19____ (Address) **Nampa Ida.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **Kohlerlawn Cem** Date of Burial **3/30/29** 19

20. Undertaker **Fred K. Robinson** Address **Nampa, Ida.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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RECEIVED APR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. S 65601Local Registrar's No. 12

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123Primary Registration District No. 2201

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Platte(a) Residence. No. St. 1300

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OF RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Mar 17-1929

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kellogg Ida
(State or country)10 NAME OF FATHER Cullis Platte11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho12 MAIDEN NAME OF MOTHER Lillian Hubbard13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho

14

Informant
(Address) Kellogg Ida

15

Filed Mar 30 19 29 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March - 16th
(Month) (Day)1929
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

3/16/1929 to 3/16/1929

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still-Birth.

_____. (duration) _____. yrs. _____. mos. _____. ds.

CONTRIBUTORY
(Secondary)

_____. (duration) _____. yrs. _____. mos. _____. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. H. Hurd, M. D.3/19/1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Kellogg Ida3/17 1929

20. Undertaker

Address

P. J. StoutKellogg

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S65952**

PLACE OF DEATH

County of Lewiston.City of Nez Perce.Registration District No. 96Primary Registration District No. 1009(No. White Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Stillborn Carter.(a) Residence. No. 1426 Main St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3/26/29.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

10. NAME OF FATHER Vesley Carter.

11. BIRTHPLACE OF FATHER (city or town) The Dalles.
(State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Bernice Rogers.

18. BIRTHPLACE OF MOTHER (city or town) Elgin,
(State or Country) Oregon.

14. Informant Wesley Carter.
(Address) Lewiston, Idaho.

15. Filed Apr 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26th, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 26, 1929, to May 26, 1929
that I last saw him alive on March 26, 1929

and that death occurred, on the date stated above, at bedroom m.
The CAUSE OF DEATH* was as follows: became death before birth.

Still-born premature 6 months
Cause apparently unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

none known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none found

(Signed) E. L. White., M. D.
3/27/29., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 3/27/29. 19

20. Undertaker Brower-Vann Company. Address Lewiston, Idaho

PARENTS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Over from March 29

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUN 7 1929

RECEIVED JUN 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S66150**

PLACE OF DEATH

County of Bonner

Registration District No. 78

Local Registrar's No. _____

City of Kootenai

Primary Registration District No. 2155

(No. Kootenai, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Mosolf Stillborn

(a) Residence. No. _____ St. Kootenai, Idaho

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2, 1929.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kootenai Idaho
(State or country)

10. NAME OF FATHER

Otto G. Mosolf

11. BIRTHPLACE OF FATHER (city or town) Glasstown N. Dak.
(State or Country)

12. MAIDEN NAME OF MOTHER

Helma Johnson

13. BIRTHPLACE OF MOTHER (city or town) Daggart Mich.
(State or Country)

14. Informant Otto G. Mosolf
(Address) Kootenai, Idaho.

15. Filed May 3, 1929 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 2, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Difficult Labor
Terminates in Perseveration
Stillborn 9 months
(duration) yrs. mos. ds.
CONTRIBUTORY Valvular Heart Disease
(Secondary) and ill health generally of mother
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) B. E. Coleman M.D.
5-9, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Pinecrest May 3, 1929

20. Undertaker Address

Moon Mortuary Sandpoint, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S66155**

PLACE OF DEATH

County of Bonniville

City of Idaho Falls Registration District No. 3

Primary Registration District No. 2

Local Registrar's No. 73

(No. H. O. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Street

(a) Residence. No. 206 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3-29

7. AGE Years no Months no Days no If LESS than 1 day, 0 hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country)

10. NAME OF FATHER W Street

11. BIRTHPLACE OF FATHER (city or town) Haystack Utah (State or country)

12. MAIDEN NAME OF MOTHER Mary C Peterson

13. BIRTHPLACE OF MOTHER (city or town) Chaparral Idaho (State or country)

14. Informant W Street (Address) Idaho Falls, Ida

15. Filed Apr 3, 1929 W Street Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 1929, to 19, 1929

that I last saw him on 19, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

fall from
mother's lap
(duration) yrs. mos. no ds.

CONTRIBUTORY Same (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted at if not at place of death?

Did an operation precede death? Caesarian

Was there an autopsy? no

What test confirmed diagnosis as above

(Signed) W Street, M. D.

4-3, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida Date of Burial 4/4 1929

20. Undertaker W. F. M. Han Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 13 1929

PLACE OF DEATH

County of Cassia

City of Burley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 711-N. Schodde, Burley)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. S 66539

Local Registrar's No.

2. FULL NAME

(a) Residence. No. 711-North Schodde St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18-1929

7. AGE Years Months Days 0 LESS than 1 day, 8 hrs. or 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burley, Idaho (State or country)

10. NAME OF FATHER Earl Jones

11. BIRTHPLACE OF FATHER (city or town) Kansas (State or Country)

12. MAIDEN NAME OF MOTHER Ruby Anderson

13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country)

14. Informant Mr. Earl Jones, (Father) (Address) Burley Idaho

15. Filed 7-6, 1929 H. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 18, 1929, that I last saw her alive on June 18, 1929, and that death occurred, on the date stated above, at 8:00 P.m.

The CAUSE OF DEATH* was as follows: Index Album Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) Hugh E. Jones, M. D.

June 19, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Date of Burial June 19 1929

20. Undertaker D. C. Johnson Address Burley Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **S66640**

PLACE OF DEATH
County of Madison
City of Rehburg

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 49

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Otteson
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>S</u>	
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____			
6. DATE OF BIRTH (month, day and year)			
7. AGE	Years	Months	Days
			If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work _____			
(b) General nature of industry, business, or establishment in which employed (or employer) _____			
(c) Name of employer _____			

9. BIRTHPLACE (city or town) Rehburg
(State or country)

10. NAME OF FATHER 2nd Wallace Otteson

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Flora M. Comphouse

13. BIRTHPLACE OF MOTHER (city or town) _____
(State or Country)

14. Informant Otto Wallace Otteson
(Address) Rehburg Idaho

15. Filed 7/5, 19 29
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (about) 25-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Premature (Born dead about 10 days before delivery)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
If not at place of death? _____
Did an operation precede death? _____ Date of _____

Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) Farley Nelson M. D.
July 5, 1929 (Address) Rehburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Sugar City</u>	Date of Burial 19____
20. Undertaker	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 66712**

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37Primary Registration District No. 2085Local Registrar's No. 400(No. #2 Hansen Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Hansen Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Feb. 8 - 1928

7. AGE Years Months Days If LESS than 1 day,
- - - - - 0 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls Idaho
(State or country)10. NAME OF FATHER William Wilson11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Hetta Weighall13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Mr. Lewis Wilson
(Address) #2 - Hansen Idaho

15. Filed 7-10, 1928 W. J. L.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 8 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h still alive to 10 1928
alive on Feb. 8, 1928

and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Strangulation from con-
pression of cord in
birth equal
(duration) yrs. mos. ds. ✓

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Davis M. D.Feb. 9 1929 (Address) Kimberly St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Filer Cemetery 19
Address

20. Undertaker J. E. Drake Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

PLACE OF DEATH

County of Bingham

City of Shelley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

DO NOT WRITE IN THIS SPACE

State File No. S66852

Local Registrar's No. 133

(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Belnap

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day and year)

7. AGE Born dead Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Idaho

10. NAME OF FATHER Rev. Belnap

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salem Idaho

12. MAIDEN NAME OF MOTHER Laura Smith Loveland

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washakia Wyo

14. Informant George Belnap (Address) Shelley Idaho

15. Filed July 17, 1929 W. H. Baker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13 29 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Born dead

that I last saw h. alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cord around neck
Strangled (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of _____

Was there an autopsy? ✓

What test confirmed diagnosis? (Signed) J. W. McKee M. D.

July 13, 1929 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Sugar City Idaho

7-13-1929

20. Undertaker

Address

7

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUL 22 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 66881**County of BattleCity of MooreRegistration District No. 59Primary Registration District No. 2129Local Registrar's No. 6(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME May Jensen(a) Residence No. Moore, Idaho St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE int. 5. Single, Married, Widowed, or Divorced (write the word) single6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓6. DATE OF BIRTH (month, day and year) May 5 - 19297. AGE Years Months Days If LESS than 1 day, hrs. or min.
still birth

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9. BIRTHPLACE (city or town) Moore, Idaho
(State or country)10. NAME OF FATHER Joseph E. Jensen11. BIRTHPLACE OF FATHER (city or town) Logan, Utah
(State or Country)12. MAIDEN NAME OF MOTHER Lara Sorensen13. BIRTHPLACE OF MOTHER (city or town) Logan, Utah
(State or Country)14. Informant Joseph E. Jensen
(Address) Moore, Idaho15. Filed May 7, 1929 W. Salt
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5
(Month) (Day) (Year) 192917. I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 5, 1929
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH was as follows:
Still birthCONTRIBUTORY
(Secondary)18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. H. Jackson
May 5, 1929 (Address) Moore, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moore, Idaho Date of Burial May 5 192920. Undertaker Geo. R. Larmie Address Moore, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. 1-1918 AUG 9 1929

1. PLACE OF DEATH
County of Idaho
City of St. Anthony
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 99
Primary Registration District No. 2177
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 86955
Local Registrar's No. 292

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby McArthur, 704

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE & SINGLE, MARRIED, WID-
OWED OR DIVORCED White Single
(Write the word)

5. DATE OF BIRTH

Aug 5 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?
0 min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) St. Anthony Idaho

10. NAME OF FATHER

Frank McArthur

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Gwendolyn Douglas

13. BIRTHPLACE OF MOTHER

(State or Country) St. Anthony Idg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug 5

19

W. W. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Don't Know.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1929 to 19,
that I last saw him alive on not at all 19,
and that death occurred on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:

Ancephalic Monstrosity
Still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Hansen M. D.
19 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Pelton

DATE OF BURIAL

Aug 5 - 1929

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929
 PLACE OF DEATH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 67005**

County of *Butte*

Registration District No. *50*

City of *Paris, Idaho*

Primary Registration District No. *1050*

Local Registrar's No. *105*

(No. *1050* *1050*)
 (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Infant Powell*

(a) Residence. No. *1050* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6. DATE OF BIRTH (month, day and year) *July 22, 1929*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Paris, Idaho*
 (State or country)

10. NAME OF FATHER *E. J. Powell*

11. BIRTHPLACE OF FATHER (city or town) *Idaho*
 (State or Country)

12. MAIDEN NAME OF MOTHER *May M. Barker*

13. BIRTHPLACE OF MOTHER (city or town) *Idaho*
 (State or Country)

14. Informant *E. J. Powell*
 (Address) *Paris, Idaho*

15. Filed *7/29*, 1929, *H. J. Sturges*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 22*, 19*29*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July, 1929, to *July*, 1929
 that I last saw *alive* on *Switzerland*
 and that death occurred, on the date stated above, at *90* m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
 (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
 if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *exam*

(Signed) *Harold J. Sturges*, M. D.

7-23, 1929 (Address) *Paris, Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Frank Cemetery

7/28, 1929

Undertaker

Address

P. B. M. M.

Paris, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S67006**

County of Boone
City of Camden

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 106

(No. Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 0009

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds.

St. _____

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

July 22, 1929

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant

(Address)

15. Filed

7/29

1929

H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 22 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July, 1929, to July, 1929
that I last saw him alive on 5th Nov 1929

and that death occurred, on the date stated above, at 90 m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges, M. D.

7-23, 1929 (Address) Camden

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Forest Cemetery 7/23 1929

20. Undertaker

Address

R. B. Mooney Camden

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RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67170 S

PLACE OF DEATH

County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56082. FULL NAME INFANT HOWELL

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) JUNE 30, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILLBORN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO
(State or country) IDA.

10. NAME OF FATHER LE VERE HOWELL

11. BIRTHPLACE OF FATHER (city or town) CLIFTON, IDA
(State or Country)

12. MAIDEN NAME OF MOTHER LARUE BROWER

13. BIRTHPLACE OF MOTHER (city or town) IDAHO FALLS, IDAHO
(State or Country)

14. Informant LE VERE HOWELL
(Address) CLIFTON, IDAHO.

15. Filed 7/3, 1929 Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30, 1929, to 6-30, 1929
that I last saw him alive on still born, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

still born

(duration) yrs. mos. ds.
CONTRIBUTORY Respiratory distress
(Secondary) in mother. 7 ds.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) W. W. Butcher M. D.
7-3, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal CLIFTON, IDAHO Date of Burial JUNE 30, 1929

20. Undertaker ARTHUR W. HALL Address POCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **S67544**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 13
City of Idaho Falls Primary Registration District No. 213-0

Local Registrar's No. 162

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Foster
(a) Residence. No. 379 Java St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) Sept 3 - 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Idaho Falls
10. NAME OF FATHER Richard Foster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Anna Klugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant Richard Holland
(Address) P.O. 2, Idaho Falls
15. Filed Sept 4, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 3 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 3, 1929
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Do not know
(duration) yrs. mos. ds.
18. Where was disease contracted ✓
if not at place of death? ✓
Did an operation precede death? ✓ Date of _____
Was there an autopsy? ✓
What test confirmed diagnosis? Stillborn M. D. _____
(Signed) _____
_____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Date of Burial Sept 4 1929
20. Undertaker V. F. M. Han Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67840 S

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004

Local Registrar's No. 206

(No. St. Lukas Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Rounds.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6. DATE OF BIRTH (month, day and year) October 20th 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

William Rounds.

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Iowa.

12. MAIDEN NAME OF MOTHER

Mazie Brown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Maryland.

14. Informant William Rounds.

(Address) Boise, Idaho R. #1

15. Filed 10-21-29 1929 W. J. Phelan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 20th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19, that I last saw h. alive on, 19, and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Premature Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother has high blood pressure (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Coats M. D.

10/21/29, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery

10-21-29

20. Undertaker

Wm. McBratney.

Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 58100**

County *Idaho Falls*
City of *Idaho Falls*

Registration District No. *37*

Primary Registration District No. *1195*

Local Registrar's No. *206*

(No. *Hospital*)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Morris*

(a) Residence. No. *277 Quincy* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) *Idaho*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address)

15. Filed *11-5-29*, 19 *Dr. D. M. Cowgill* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 21* 1929

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct. 1* 1929, *Still born*, 19

that I last saw him *still born*, 19 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature birth 5 months

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) *B. D. Weaver*, M. D.

10/22, 1929 (Address) *Twin Falls*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls

19

20. Undertaker

Address

F. E. Drape

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

City of Nairobi

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

State File No. **68302**

Local Registrar's No. 20

(Usual place of abode)

Length of residence in city or town where death occurred.	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.
---	------	------	-----	---	------	------	-----

MEDICAL CERTIFICATE OF DEATH

If LESS than 1 day _____ hrs. or _____ min.

15. Filed 11 8 19 29

20. Underskrift	Address
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Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 5 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68405

S

County of Minidoka

Registration District No.

City of Rupert

Primary Registration District No.

Local Registrar's No. 61

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born - Choules

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
0 0 0 If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rupert Idaho
(State or country)

10 NAME OF FATHER George Choules

11 BIRTHPLACE OF FATHER (city or town) Preston Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Esther Henderson

13 BIRTHPLACE OF MOTHER (city or town) Provo Utah
(State or country)

14 Informant George Choules
(Address) Heyburn Idaho

15 Filed 11-11 1929 Estelma
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 17 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Death in uterus about 10 days before delivery. Cause unknown
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Estelma M. D.
11-11 1929 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Heyburn Idaho Date of Burial 9-18 1929

20. Undertaker Edmund Goodman Address Rupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicæmia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		S	
County of <u>Campana</u>		DEPARTMENT OF PUBLIC WELFARE			
City of <u>Campana</u>		BUREAU OF VITAL STATISTICS			
No. <u>493-116 014-286</u>		CERTIFICATE OF BIRTH		167924	
St. <u>116 014-286</u>		Registration District No. <u>2</u>		State File No. <u>167924</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>1006</u>		Local Registrar's No. <u>3</u>	
FULL NAME OF CHILD <u>Infant of Mrs Abigail Millett</u>					
(If stillborn, substitute the word "Stillborn" for name of child)					
Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number and In order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Jan 16</u> 19 <u>29</u>	
				(Month)	(Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>None</u>					
Number of child of this mother, including present birth <u>2</u> (a) Born alive and now living <u>1</u>					
Born alive but now dead _____ Stillborn <u>1</u>					
FATHER			MOTHER		
FULL NAME <u>George Ernest Millett</u>			FULL MAIDEN NAME <u>Abigail Hoernicke</u>		
Residence (Usual place of abode) <u>Campana</u>			Residence (Usual place of abode) <u>Campana</u>		
If nonresident, give place and State _____			If nonresident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>31</u> (Years)			Color or race <u>White</u> Age at last Birthday <u>27</u> (Years)		
Birthplace <u>Utah</u> (City and State or Country)			Birthplace <u>Alaska Canada</u> (City and State or Country)		
Occupation _____			Occupation <u>Wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn Dead alive at 9:15 P. M.
on the date above stated.

(Signature) Samuel Abwayne

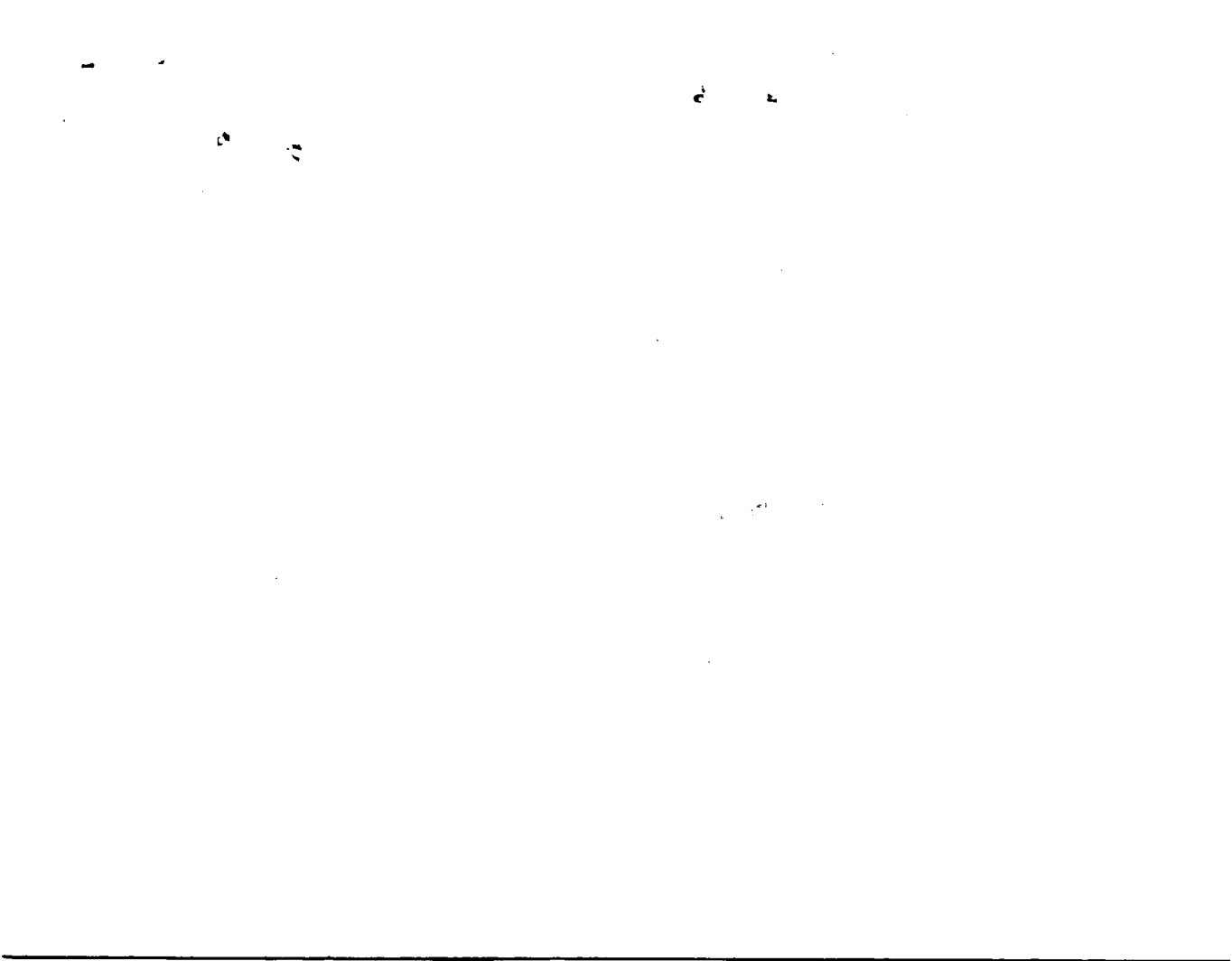
(Physician or midwife)

Address Campana, Idaho

Filed 2-4 1929 Butch Conway

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5-20M-1-16-12 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of _____ Primary Registration District No. _____
City of _____ (No. _____ St.) Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Male Milleth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1-16-1929
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many . hrs. or mins.
✓ yrs. ✓ mos. ✓ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9. BIRTHPLACE Nampa, Idaho
(State or Country)

10. NAME OF FATHER George W. Milleth

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER Abigail Shomaker

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15. _____

Filed 1929 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 1-16-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-16-1929 to 1-16-1929, that I last saw him alive on 1-16-1929

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - 7 mo gestation.
Hydrocephalus

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Samuel A. Sweeney D.

1-17-1929 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Voluntarily 1929

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (o) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED FEB 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Clearwater

City of Bojone

No. 27121708913 St.

Hayden Lane
(If born in hospital or institution
give name)

Registration District No. 90

State File No. 68033

Prim. Registration District No. 2468

Local Registrar's No. 7

FULL NAME OF CHILD Donna May

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month)

(Day)

1929
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth one

(a) Born alive and now living 0

Born alive but now dead one

Stillborn ✓

FATHER
FULL
NAME

Dwain

FATHER

Spae

Residence (Usual place of abode)

Grapple Ida

If nonresident, give place and State

Color or race

white

Age at last Birthday

26
(Years)

Birthplace

Grapple Idaho

(City and State or Country)

Occupation

farmer

MOTHER
FULL
MAIDEN
NAME

Ada Alice Ratliff

MOTHER

Residence (Usual place of abode)

Grapple

If nonresident, give place and State

Color or race

white

Age at last Birthday

18
(Years)

Birthplace

Graymont Idaho

(City and State or Country)

Occupation

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

{ Born alive
Stillborn }

at 12:15 P. M.

(Signature)

Dr. F. Robertson

Dr. F. Robertson's Consultant
on A.S.

(Physician or midwife)

Address

Bojone, Idaho

Filed

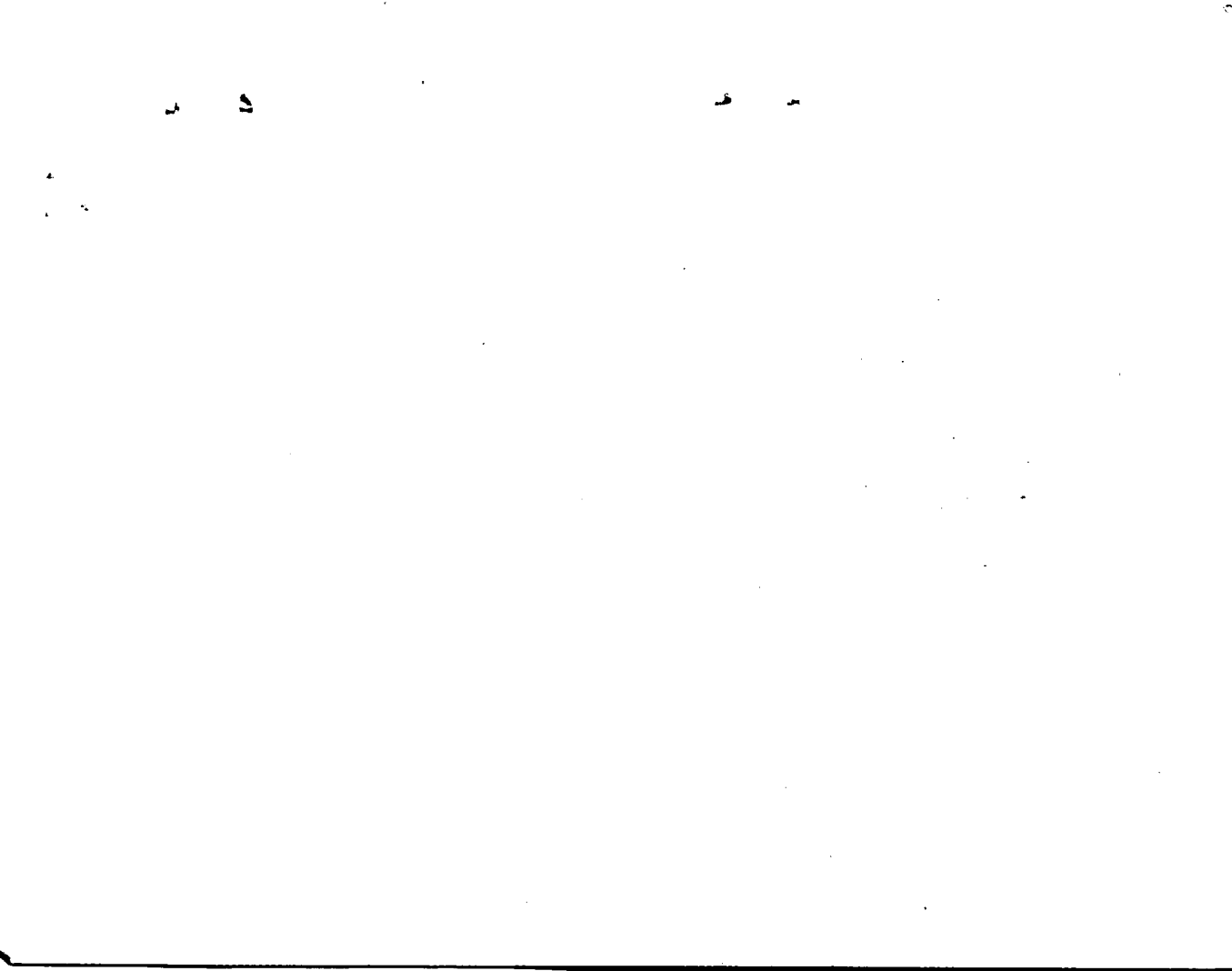
Jan. 4

19

Dr. W. A. Shaw

Registrar.

{ *Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth. }



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED FEB 11 1929

PLACE OF DEATH

County of Blaine

City of Arden

Registration District No. 2168

Primary Registration District No. 2168

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64555

Local Registrar's No. 11

2. FULL NAME Born dead

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 1-17-29

7. AGE Years Months Days If LESS than 1 day, hrs. or min. ✓ ✓ ✓ ✓ ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) Ida (State or country)

10. NAME OF FATHER Frank Spahr

11. BIRTHPLACE OF FATHER (city or town) Ida (State or Country)

12. MAIDEN NAME OF MOTHER Ada Catliff

13. BIRTHPLACE OF MOTHER (city or town) Ida (State or Country)

14. Informant Frank Spahr (Address) Ida

15. Filed Jan 30 1929 Rep. W. A. Spahr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1-17-29 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-17, 1929, to 1-17, 1929

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 11:45 m.

The CAUSE OF DEATH* was as follows:

Forceps and
podalic version

(duration) _____ yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓ (duration) _____ yrs. mos. ds.

18. Where was disease contracted ✓ if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Dr. Hopkins

(Signed) Dr. Robertson M. D.

1-17, 1929 (Address) Arden Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ida Date of Burial Jan 18 1929

20. Undertaker W. A. Spahr Address Arden

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED FEB 6 1929
County of Franklin
City of Dayton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 168073

No. St.

243211021-284

(If born in hospital or institution
give name.)

Registration District No. 27 State File No.

Prim. Registration District No. 2119 Local Registrar's No. 4

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Jan. 11</u> <u>1929</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 20 Ag.

Number of child of this mother, including present birth 10 (a) Born alive and now living 9

Born alive but now dead Stillborn

FATHER
FULL NAME David W. Butters

Residence (Usual place of abode) Dayton, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 47

Birthplace Utah (Years)

Occupation Age & State of Country

MOTHER
FULL MAIDEN NAME Vaude Shumway

Residence (Usual place of abode) Dayton, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 47

Birthplace Utah (Years)

Occupation Housewife (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive {
on the date above stated. Stillborn { 3:30 P. M.

(Signature) A. P. C. C. C.

Physician

(Physician or midwife)

Address Preston, Idaho

Filed Feb. 1, 1929

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-19-2000 BY 60322 UCBAW/STP

County of _____
City of _____
State _____
Date _____
Page _____

STATE OF _____
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
Prima Registration District No. _____ Local Registrar's No. _____

LEGAL NAME OF CHILD

_____ (Child's name in English)
_____ (Child's name in Spanish)

Sex of child _____ Date of birth _____
Place of birth _____
Date of birth _____
Place of birth _____

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth _____
(a) Born alive and now living _____
(b) Born dead _____

Place of birth _____
Date of birth _____
Place of birth _____

Place of birth _____
Date of birth _____
Place of birth _____

Place of birth _____
Date of birth _____
Place of birth _____

Place of birth _____
Date of birth _____
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Place of birth _____

Place of birth _____
Date of birth _____
Place of birth _____

Place of birth _____
Date of birth _____
Place of birth _____

Place of birth _____
Date of birth _____
Place of birth _____

* Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A birth record is one that neither registers nor shows other evidence of its later birth.

I hereby certify that I attended the birth of this child, who was _____
(Signature) _____
Address _____
Filed _____

RECEIVED FEB 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64581

PLACE OF DEATH

County of Franklin

City of Dayton

Registration District No. 21

Primary Registration District No. 2119

Local Registrar's No. 7

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Butters

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 11, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Dayton, Idaho
(State or country)

10. NAME OF FATHER David W. Butters

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Maude Shumway

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant David W. Butters
(Address) Dayton, Idaho15. Filed Feb. 2, 1929 A. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown, Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.
1-12-29, 19____ (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Dayton, Idaho 19____

20. Undertaker Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

168073 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

RECEIVED FEB 7 1929

PLACE OF BIRTH

552-126 629 926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Moscow

No. 1st & Jackson St.

Hospital Indian Empire

Registration District No. 101

File No.

Primary Registration District No. 1011

Registered No.

CERTIFICATE OF BIRTH **168255**

FULL NAME OF CHILD

Gale Ness

(Certificate of no value without full name of child.)

Sex of Child male

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

Yes.

Date of
birth

Jan 26th

1929

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacterioid solution was used in eyes?

Ag. no. 3

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. 0

FULL
NAME

FATHER

Sigurd Ness

FULL
MAIDEN
NAME

MOTHER

Grace-Catherine Isom

RESIDENCE

Moscow Ida.

RESIDENCE

Moscow

COLOR

White

AGE AT LAST
BIRTHDAY

31

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

30

(Years)

BIRTHPLACE

Id.

BIRTHPLACE

Id.

OCCUPATION

meat cutter

OCCUPATION

Attf.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Shirley at 12:50 P. M.
Born alive or stillborn

Magel
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1929

W. H. Withers

Registrar.

Registrar.

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. The document outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

The second part of the document focuses on the implementation of the proposed changes. It details the steps involved in the process, from the initial planning stage to the final execution. The document also addresses the potential challenges that may arise during the implementation phase and provides strategies to overcome them.

The third part of the document discusses the results of the implementation. It presents the data collected and analyzes the outcomes of the changes. The document highlights the areas where the changes have been successful and identifies the areas that still need improvement. It also provides recommendations for future actions to ensure the continued success of the organization.

The fourth part of the document discusses the conclusions and recommendations. It summarizes the key findings of the study and provides recommendations for the organization based on the results. The document also discusses the limitations of the study and suggests areas for further research.

The fifth part of the document discusses the appendix. It includes additional information that supports the main text of the document, such as data tables, charts, and graphs. The appendix provides a detailed look at the data used in the study and allows readers to verify the results.

The sixth part of the document discusses the bibliography. It lists the sources used in the study, including books, articles, and websites. The bibliography provides a comprehensive list of the references used in the document, allowing readers to locate the original sources if needed.

The seventh part of the document discusses the index. It provides a list of the topics covered in the document, along with the page numbers where they can be found. The index allows readers to quickly locate the information they are looking for in the document.

The eighth part of the document discusses the glossary. It defines the key terms used in the document, ensuring that all readers have a clear understanding of the terminology. The glossary is a useful reference tool for readers who are unfamiliar with the terms used in the document.

The ninth part of the document discusses the acknowledgments. It expresses gratitude to the individuals and organizations that have supported the study. The acknowledgments provide a chance for the author to thank those who have helped make the study possible.

The tenth part of the document discusses the conclusion. It summarizes the main findings of the study and provides a final recommendation for the organization. The conclusion is the final section of the document and provides a clear and concise summary of the entire study.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 7 1929

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. _____, _____ St.)

File No. 64645
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Ness (Stillborn)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Jan. 26 1929
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
how many _____ hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Sigurd Ness

11. BIRTHPLACE OF FATHER Haten North Dakota
(State or Country)

12. MAIDEN NAME OF MOTHER Grace Isom

13. BIRTHPLACE OF MOTHER Allinee Nebraska
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sigurd Ness
(Address) Moscow Idaho.

15. Filed Jan 26 1929 W. H. Baruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1929
that I last saw him Stillborn 1929
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Precipitate Labor.
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. Magee M. D.
1/29 19 29 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Moscow Idaho. DATE OF BURIAL 1-29 1929

20. UNDERTAKER H. R. Short ADDRESS Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED FEB 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka

City of Rupert

No. 643-105074-331

St. Registration District No. 19 State File No. 168297

Hospital _____ Primary Registration District No. 2015 Local Registrar's No. 14

FULL NAME OF CHILD Umanah

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 5</u> 192 <u>9</u> (Month) (Day) (Year)
--------------------------	---	-----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Hermon P. Fails
RESIDENCE Rupert, Idaho
COLOR white AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Ohio
OCCUPATION Cream Buyer

MOTHER
FULL MAIDEN NAME Mabel Clark
RESIDENCE Rupert, Idaho
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7¹⁰ A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Deland Lewis, M.D.

(Physician or midwife)

Address Rupert, Idaho

Filed 2-6 1929 W. H. Lewis

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

FEB 11 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

168370

County of

City of

No. St.

215-226 042-215

(If born in hospital or institution
give name.)

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Female	Twin Triplet or other?	1	and	Number in order of birth	1st	Legiti- mate	Yes	Date of birth	26- Jan - 1929	
									(Month)	(Day)	(Year)
(To be answered only in event of plural births)											

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1st (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER

FULL NAME

Residence (Usual place of abode)

If nonresident, give place and State

Color or race Age at last Birthday

(Years)

Birthplace
(City and State or Country)

Occupation

MOTHER

FULL MAIDEN NAME Elsie Sanders

Residence (Usual place of abode) Castleford, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 18

(Years)

Birthplace Lona, B. D.
(City and State or Country)

Occupation none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive ☒ Stillborn ☐ at 11:30 A. M.
on the date above stated.

(Signature) J. W. MacMann

(Physician or midwife)

Address Buhl, Ida.

Filed 1-28 1929 J. H. Thompson

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Ed Karick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1 FEB 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64753

PLACE OF DEATH
County of Trin. Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Buby Sanders

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years ✓ Months ✓ Days ✓ If LESS than 1 day, ✓ hrs. or ✓ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) Buhl Ida.
(State or country)

10. NAME OF FATHER Dan Know

11. BIRTHPLACE OF FATHER (city or town) Dan Know
(State or Country)

12. MAIDEN NAME OF MOTHER Elsie Sanders

13. BIRTHPLACE OF MOTHER (city or town) S. Dakota
(State or Country)

14. Informant Ed. Kanner
(Address) Buhl

15. Filed 1-27, 1929. J. H. Wampler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 26, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stitcher, 1929

that I last saw him alive on Jan. 26, 1929

and that death occurred, on the date stated above, at ✓ m.

The CAUSE OF DEATH* was as follows:

unknown

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary)

(duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Wampler M. D.
1929 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Ida Date of Burial Jan 27, 1929

20. Undertaker J. H. Wampler Address Buhl Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Twin Falls</u>	DEPARTMENT OF PUBLIC WELFARE		
City of <u>Twin Falls</u>	BUREAU OF VITAL STATISTICS		
No. <u>133104042 275</u> St.	CERTIFICATE OF BIRTH		
<u>Twin Falls Co. In Idaho</u> Registration District No. <u>37</u>		State File No. <u>168415</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>1085</u> Local Registrar's No. _____	
FULL NAME OF CHILD <u>Stillbirth</u> <u>Allan</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>
			Date of birth <u>Jan</u> <u>4</u> <u>1929</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____			
Number of child of this mother, including present birth <u>5</u> (a) Born alive and now living <u>5</u>			
Born alive but now dead <u>1</u> Stillborn <u>1</u>			
FATHER		MOTHER	
FULL NAME <u>William James Allan</u>		FULL MAIDEN NAME <u>Margaret Spurrin</u>	
Residence (Usual place of abode) <u>131 Walnut</u>		Residence (Usual place of abode) <u>131 Walnut</u>	
If nonresident, give place and State <u>Buhl, Idaho</u>		If nonresident, give place and State <u>Buhl, Idaho</u>	
Color or race <u>W</u> Age at last Birthday <u>36</u> (Years)		Color or race <u>W</u> Age at last Birthday <u>30</u> (Years)	
Birthplace <u>Butte Montana</u> (City and State or Country)		Birthplace <u>Allan Montana</u> (City and State or Country)	
Occupation <u>Labo</u>		Occupation <u>house wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive } at 3 15 P. M.
on the date above stated. {
Stillborn }

(Signature) J. W. Maxson

(Physician or midwife)

Address Buhl, Idaho

Filed 1-10-29

1929

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

COMMUNICATIONS SECTION
DEPT. OF JUSTICE
WASHINGTON, D. C. 20535

Print Registration District No. _____ Local Board _____

CLINTON TO NEW YORK, 1940

CHINA

What was the result? It was used to prevent the spread of the disease.

Number of birds of this species, including present ones _____ (2) How often are they taken

From all over the world

東洋生IT丸電

11-11-74

SEP 1962

(mode to grade level) variables

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

Page 10 of 10

(P. 1)

City and State of Georgia)

2024/07/17

SECRET

no date above stated.

(S) (U)

*There is no attending physician or midwife, and the father, householder, etc., should be present. A child is one that neither breathes nor shows other evidence of life after birth.

82516A

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~~EX-100-80-640947~~

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Boomer MAR 6 1929 STATE OF IDAHO
County of Boomer DEPARTMENT OF PUBLIC WELFARE
City of San Juan (rural) BUREAU OF VITAL STATISTICS
No. 246-103 009-319 CERTIFICATE OF BIRTH
Registration District No. 78 State File No. 168627
(If born in hospital or institution
give name.)
Prim. Registration District No. 2155 Local Registrar's No. —
FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>No</u>	Date of birth <u>2 3 1929</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum No

Number of child of this mother, including present birth 1 (a) Born alive and now living None

Born alive but now dead — Stillborn Yes

FATHER
FULL NAME Howard Koffel

Residence (Usual place of abode) Paik River

If nonresident, give place and State —

Color or race White Age at last Birth — (Years)

Birthplace Kansas
(City and State or Country)

Occupation Laborer

MOTHER
FULL MAIDEN NAME Lady's Lantz

Residence (Usual place of abode) Paik River

If nonresident, give place and State —

Color or race White Age at last Birthday 16 (Years)

Birthplace Idaho
(City and State or Country)

Occupation School Girl

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P M.
on the date above stated.

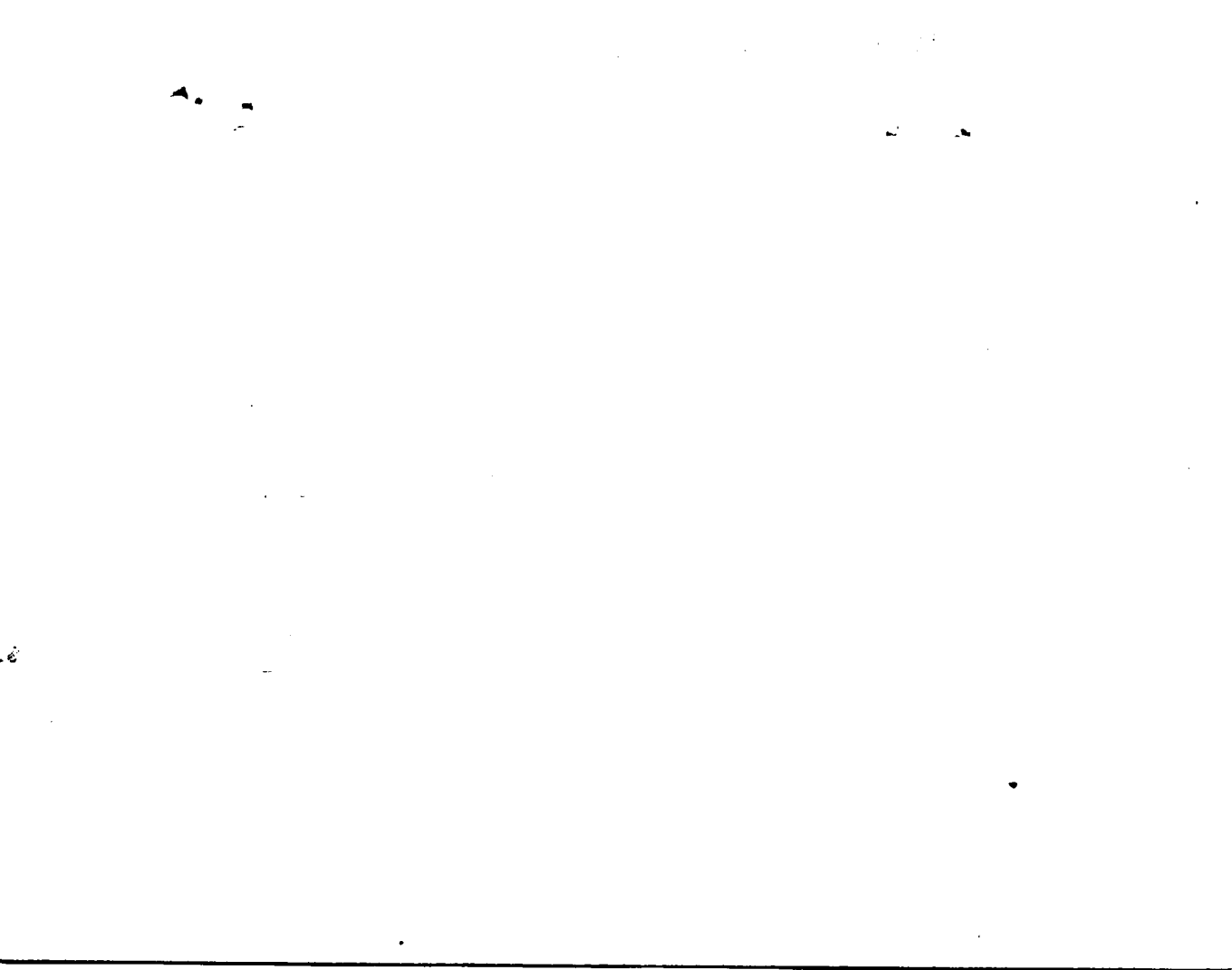
(Signature) C. E. Carson

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address San Juan

Filed March 4 1929 Viola Allen
Deputy Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929
PLACE OF DEATH

County of Bonner
City of Sandpoint, Ida.
(rural)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76
Primary Registration District No. 2155

DO NOT WRITE IN THIS SPACE

State File No. 64886

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3, 1929

7. AGE Years Stillborn Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint, Ida.
(State or country) rural

10. NAME OF FATHER Howard Koffel

11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Gladys Lortz

13. BIRTHPLACE OF MOTHER (city or town) neb.
(State or Country)

14. Informant A. E. Lortz
(Address) Sandpoint, Idaho (rural)

15. Filed Feb 4, 1929 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Born 2-3, 1929, to 19,
that I last saw h alive on 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

9 mo. gestation
(duration) yrs. mos. ds.

CONTRIBUTORY Difficult labor
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. E. Allen M.D. M. D.
Feb. 4, 1929 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sandpoint, Ida. (rural) Date of Burial Feb. 5 1929
Pack River, Bonner Co.

20. Undertaker A. E. Lortz Address Sandpoint, Idaho
grand father

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

554 218 019 239
PLACE OF BIRTH. Idaho MAR 6 1929
County of Booner
City of Sandpoint
No. _____ St. _____
Parnell
(If born in hospital or institution give name.)
Registration District No. 76 State File No. 168631
Prim. Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD Stillborn Nedde
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child female Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth Feb. 18 1929
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? none
Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn _____
FATHER FULL NAME Franklin Nedde MOTHER FULL MAIDEN NAME Mildred Stith
Residence (Usual place of abode) Sandpoint, Ida. Residence (Usual place of abode) Sandpoint, Ida.
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 32 Color or race White Age at last Birthday 23
(Years) (Years)
Birthplace London Ohio Birthplace Deer Lodge Mont.
(City and State or Country) (City and State or Country)
Occupation Auto mechanic Occupation housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was Stillborn at 6:30 P. M.
on the date above stated. (Signature) Floyd G. Wendt
M. D.
(Physician or midwife)
Address Sandpoint, Idaho
Filed March 4 1929 Viola Allen
Deputy Registrar.

I hereby certify that I attended the birth of this child, who was born on the date above stated.
 I hereby certify that I attended the birth of this child, who was born on the date above stated.
 I hereby certify that I attended the birth of this child, who was born on the date above stated.

Where there was no attending physician or midwife, then the father, mother, or other person who attended the birth of the child is one that another person, not shown other evidence of the attending physician.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

Signature

Date

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Occupation

City and State or Country

City and State or Country

Color of hair, eyes at last birthday

Color of hair, eyes at last birthday

Residence (Usual place of abode)

Residence (Usual place of abode)

FATHER

MOTHER

Number of child of this mother, including present birth

Number of child of this mother, including present birth

What prophylactic was used to prevent (Infant's) Neonatorrhoea?

Child

Sex of Child

Date of Birth

Date of Birth

Date of Birth

FULL NAME OF CHILD

(If born in hospital, give location)

Registration District No.

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **64893**

PLACE OF DEATH

County of BonnerCity of SandpointRegistration District No. 78Primary Registration District No. 2155

Local Registrar's No. _____

(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name (instead of street and number.)

2. FULL NAME Infant Nedds

(a) Residence. No. _____

St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb. 18, 19297. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Sandpoint, Ida
(State or country)10. NAME OF FATHER Franklin Nedds11. BIRTHPLACE OF FATHER (city or town) London
(State or Country) Ohio12. MAIDEN NAME OF MOTHER Mildred Stith13. BIRTHPLACE OF MOTHER (city or town) Deer Lodge
(State or Country) Montana14. Informant Franklin Nedds
(Address) Sandpoint, Ida.15. Filed Feb 18, 1929 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 19 29

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 18, 1929, to Feb 18, 1929that I last saw him alive on stillborn 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Placenta previa
8 m. gestation

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Floyd G. Wendle M. D.Feb. 18, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Pinecrest Cemetery Feb. 18, 1929

20. Undertaker Address

L. E. Moon Sandpoint
Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIPT FEB 22 1929

STATE OF IDAHO

County of Bannerville
City of Osgood, Idaho

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. St.

285 218 010 857

Registration District No. 73

State File No.

168659

(If born in hospital or institution
give name.)

Prim. Registration District No. 214 0

Local Registrar's No. 14

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate?	Date of birth <u>Jan 18</u> (Month) (Day)	<u>1929</u> (Year)
----------------------------	---	-----	---	------------------	---	-----------------------

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn

FATHER
FULL NAME Wm E. Shepherd
Residence (Usual place of abode) Osgood, Idaho

If nonresident, give place and State

Color or race white Age at last Birthday 38
(Years)

Birthplace Ashton, Idaho
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Rada Shepherd
Residence (Usual place of abode) Osgood, Idaho

If nonresident, give place and State

Color or race white Age at last Birthday 30
(Years)

Birthplace Peshburg, Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:15 a. m.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Idaho Falls

Filed 1/23 1929 [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

10 (100%)
10 (100%)
10 (100%)

no further to be done in this case.

NAME OF SUBJECT

[illegible]

It was previously noted that the use of the word "constant" was used to prevent the possibility of a constant.

1. The first of these is the fact that the Government has been unable to obtain the necessary information from the various sources which it has been able to tap.

SECRET

... (place of work) ...

11 November 1954

Color of face _____ Age at last birthday _____

[Faint, illegible markings]

CONFIDENTIAL

STATE OF TEXAS, COUNTY OF DALLAS

on the date above stated. I hereby certify that I attended the birth of this child, who was born on the date above stated.

(b)(7)(C), (b)(7)(D)

[illegible]

THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS SUBMITTED TO THE BOARD OF SUPERVISORS OF THE COUNTY OF LOS ANGELES, CALIFORNIA, FOR THE PURPOSE OF RECORDING THE SAME.

WITNESSED MY HAND AND SEAL OF OFFICE THIS 10TH DAY OF JANUARY, 1900.

JOHN W. HARRIS, County Clerk.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Franklin
City of Keosauqua Ind 3
No. 264-201021-717 St.
(If born in hospital or institution give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
S
168771
Registration District No. 27 State File No. 27
Prim. Registration District No. 2119 Local Registrar's No. 32

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1st Legitimate? yes Date of birth 2 1st 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead yes Stillborn yes

FATHER FULL NAME Dr. Arthur Bodily MOTHER FULL MAIDEN NAME Rhoda Page

Residence (Usual place of abode) Keosauqua Ind Residence (Usual place of abode) Keosauqua Ind

If nonresident, give place and State

Color or race W Age at last Birthday 36 Color or race W Age at last Birthday 27
(Years) (Years)

Birthplace Idaho Birthplace Idaho
(City and State or Country) (City and State or Country)

Occupation surgeon Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Keosauqua Ind M.
on the date above stated.

(Signature) Arthur Bodily

(Physician or midwife)

Address Keosauqua Ind

Filed 3-2 1929 Dr. Arthur
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

000

000

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

162791-7

APR 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
65327
State File No.

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Bodily
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word) -

6. If married, widowed, or divorced HUSBAND of (or) WIFE of -

6. DATE OF BIRTH (month, day and year) 2-1-29

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Fairview
(State or country)

10. NAME OF FATHER Joseph A Bodily

11. BIRTHPLACE OF FATHER (city or town) Fairview
(State or country)

12. MAIDEN NAME OF MOTHER Rhoda Page

13. BIRTHPLACE OF MOTHER (city or town) Dayton
(State or country)

14. Informant Joseph A Bodily, Father
(Address) Preston, Twp. 3

15. Filled W. H. Venable, 19 29
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 / 1 / 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1, 1929, to 2-1, 1929
that I last saw him alive on -, 19-
and that death occurred, on the date stated above, at - m.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY Eclampsia Mother
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. Cutler, M. D.
2/1, 1929 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

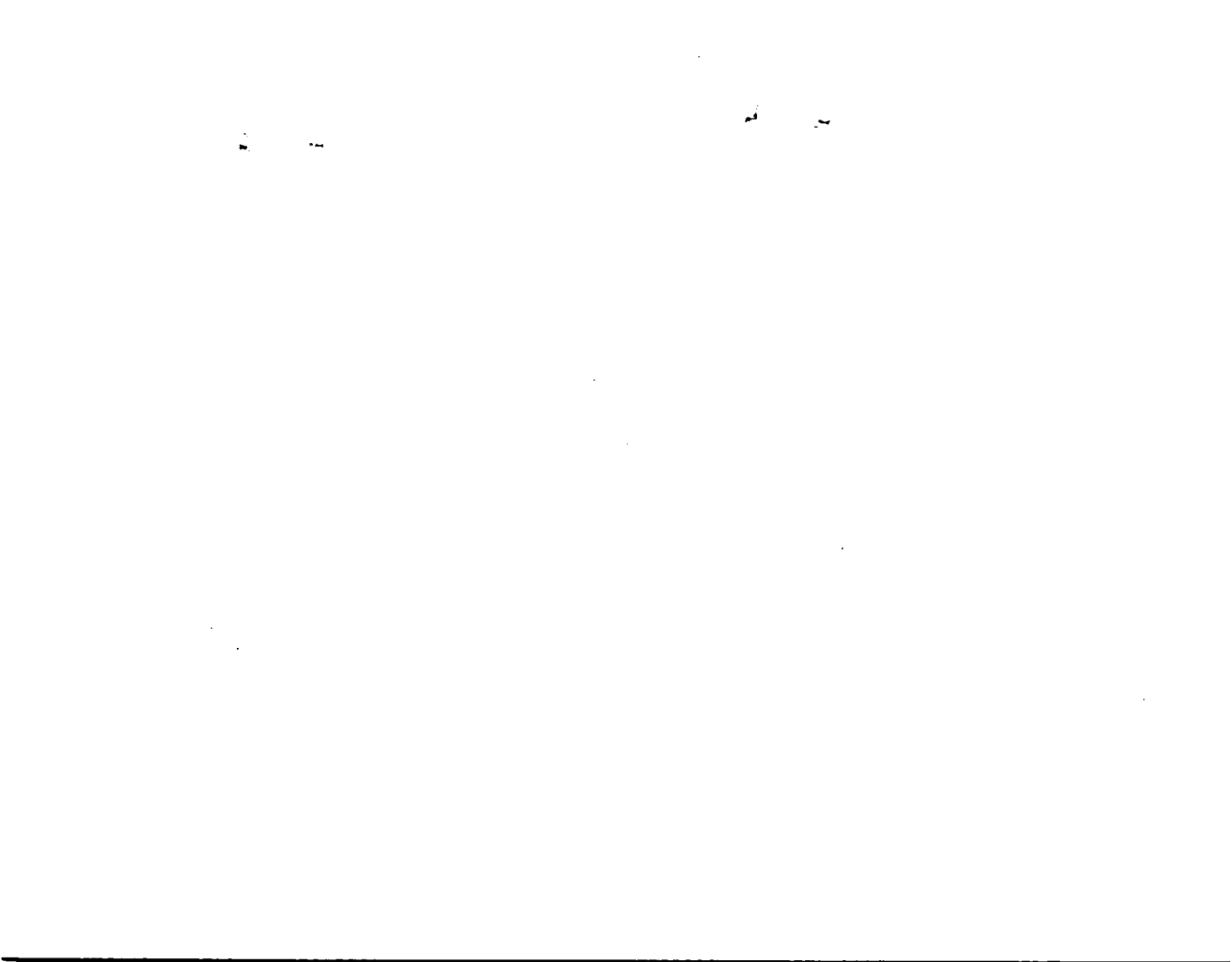
statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED MAR 8 1929		STATE OF IDAHO	
County of <u>Idaho</u>		DEPARTMENT OF PUBLIC WELFARE			
City of <u>Cottonwood</u>		BUREAU OF VITAL STATISTICS			
No. St.		CERTIFICATE OF BIRTH			
965-123 125-445 (If born in hospital or institution give name.)		Registration District No. <u>105</u>		State File No. <u>168805</u>	
FULL NAME OF CHILD <u>Stillebirth</u>		Prim. Registration District No. <u>2183</u>		Local Registrar's No. <u>8</u>	
(If stillborn, substitute the word "Stillbirth" for name of child)					
Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Feb. 23</u> 19 <u>29</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>-</u>					
Number of child of this mother, including present birth <u>11</u> (a) Born alive and now living <u>8</u>					
Born alive but now dead <u>1</u> Stillborn <u>2</u>					
FATHER FULL NAME <u>Roy Ramig</u>			MOTHER FULL MAIDEN NAME <u>Nettie Dunsmore</u>		
Residence (Usual place of abode) <u>Cottonwood</u>			Residence (Usual place of abode) <u>Cottonwood</u>		
If nonresident, give place and State _____			If nonresident, give place and State _____		
Color or race <u>W.</u> Age at last Birthday <u>41</u> (Years)			Color or race <u>W.</u> Age at last Birthday <u>43</u> (Years)		
Birthplace <u>Brandon, Iowa</u> (City and State or Country)			Birthplace <u>Carol, Iowa</u> (City and State or Country)		
Occupation _____			Occupation <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE					
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>8</u> A. M. on the date above stated.					
(Signature) <u>Wesley Orr M.D.</u> (Physician or midwife)					
Address <u>Cottonwood, Idaho</u>					
Filed <u>Feb. 28</u> 19 <u>29</u> <u>W. F. Orr D.B.</u> Registrar.					

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M.

RECEIVED MAR 2 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **65065**
Registered No. **1**

1. PLACE OF DEATH

County of **Idaho**City of **Cottonwood**Registration District No. **105**Primary Registration District No. **2193**

(No., St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Stiebbirch

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(Write the word.) **✓**

6. DATE OF BIRTH

February 23 1929
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHER**Roy Roring**11. BIRTHPLACE
OF FATHER

(State or Country)

Brandon, Iowa12. MAIDEN NAME
OF MOTHER**Nettie Dunsmore**13. BIRTHPLACE
OF MOTHER

(State or Country)

Caral, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Roy Roring

(Address)

Cottonwood

15. Filed

Feb. 23 1929 H. J. Orr J. B.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 23 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

**Obstetrical time 4 months.
Eruptive death had occurred about
2 wks. before birth. Cause unknown.**

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

2/23 1929 (Address) **Asbury F. Orr**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Cottonwood, Ida.

DATE OF BURIAL

2/23 192920. ~~DECEASED~~

ADDRESS

Roy Roring Cottonwood, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

751723 029 243

PLACE OF BIRTH RECEIVED MAR 2 1929

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

County of Latah

City of Neen Pottatch

Registration District No. 65

File No. S 168886

No. — St. —

Primary Registration District No. 2145

Registered No. —

Hospital —

FULL NAME OF CHILD Unnamed Infant Pearson

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of Birth <u>Jan. 23 1929</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

FULL NAME Ernest W. Pearson

RESIDENCE Omway

COLOR White AGE AT LAST BIRTHDAY 43
(Years)

BIRTHPLACE New Brunswick

OCCUPATION Laborer

FULL MAIDEN NAME Isabelle Bulmer

RESIDENCE Omway

COLOR White AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE Maine

OCCUPATION Housewife

Number of child of this mother, including present birth. 1

Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

(Born alive or stillborn)

5:30 a. m.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. K. Wolfe MD

(Physician or midwife)

Given names added from a supplemental report.

Address Palouse, Wash.

Filed Jan 24 1929 D. M. Thompson
Registrar

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V-1, No. 1-1-10-10-10-10-10

PLACE OF BIRTH

County of

DA

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED MAR 9 1929**
Registration District No. **65**
County of **Latah**
Primary Registration District No. **2148**
City of **Potlatch** (No. _____ St.)

File No. **65038**
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Infant Pearson**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
(Write the word.)

16. DATE OF DEATH **Stillborn Jan 23 1929**
(Month) (Day) (Year)

6. DATE OF BIRTH **Jan 23 1929**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

7. AGE _____ Yrs. _____ Mos. ☒ ds. _____
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

Stillborn
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **E. K. Wolf** M. D.
23.19.29 (Address) **Palouse, Wash.**

8. OCCUPATION **None**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

9. BIRTHPLACE **Potlatch Ida.**
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

10. NAME OF FATHER **E. W. Pearson**

Where was disease contracted if not at place of death? _____
Former or usual residence _____

11. BIRTHPLACE OF FATHER **Keweenaw Mich.**
(State or Country)

19. PLACE OF BURIAL OR REMOVAL **Potlatch Ida** DATE OF BURIAL **Jan 24 1929**
20. UNDERTAKER **E. H. Drinn** ADDRESS **Palouse**

12. MAIDEN NAME OF MOTHER **Bulmer**

13. BIRTHPLACE OF MOTHER **Maine**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **E. W. Pearson**
(Address) **Potlatch Ida**

15. Filled **Jan 24th 1929** by **D. J. Thompson**
Local Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

791117 03/314
PLACE OF BIRTH
County of Blaine
City of Winchester

MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

168897

No. _____ St. _____

Registration District No. 50 State File No. _____

Prim. Registration District No. 21 Local Registrar's No. 8

FULL NAME OF CHILD Shirley Born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>Yes</u>	Date of birth <u>Jan 17</u> (Month) (Day) (Year) <u>1929</u>
--------------------------	---	--------------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth Three (a) Born alive and now living One

Born alive but now dead Two Stillborn Two

FATHER FULL NAME <u>James Milton Brackett</u>	MOTHER FULL MAIDEN NAME <u>Mildred Caroline Lane</u>
--	---

Residence (Usual place of abode) Gifford Id

If nonresident, give place and State _____

Color or race White Age at last Birthday 26 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8:35 M. on the date above stated.

(Signature) John F. Geat

(Physician or midwife)

Address Winchester Id

Filed 19 19 29 R. E. Dwyer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAR 11 1929
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S168900

County of Levy
City of Winchester

No. 245-220-031 St. 203

(If born in hospital or institution
give name.)

Registration District No. 30

State File No. 11

Prim. Registration District No. 11

Local Registrar's No. 11

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? 1 and { Number in order of birth 1 } Legitimacy No Date of Birth Jan 20 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1

(a) Born alive and now living none

Born alive but now dead none

Stillborn one

FATHER
FULL NAME Charley Huntley
Residence (Usual place of abode) Winchester

MOTHER
FULL MAIDEN NAME Jennie Hilgers
Residence (Usual place of abode) Winchester

If nonresident, give place and State

Color or race White Age at last Birthday 26 (Years)

Birthplace Labored (City and State or Country)

Occupation

If nonresident, give place and State

Color or race White Age at last Birthday 30 (Years)

Birthplace Demary Kansas (City and State or Country)

Occupation at home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 30 A.M.
on the date above stated.

(Signature) Late only
after care

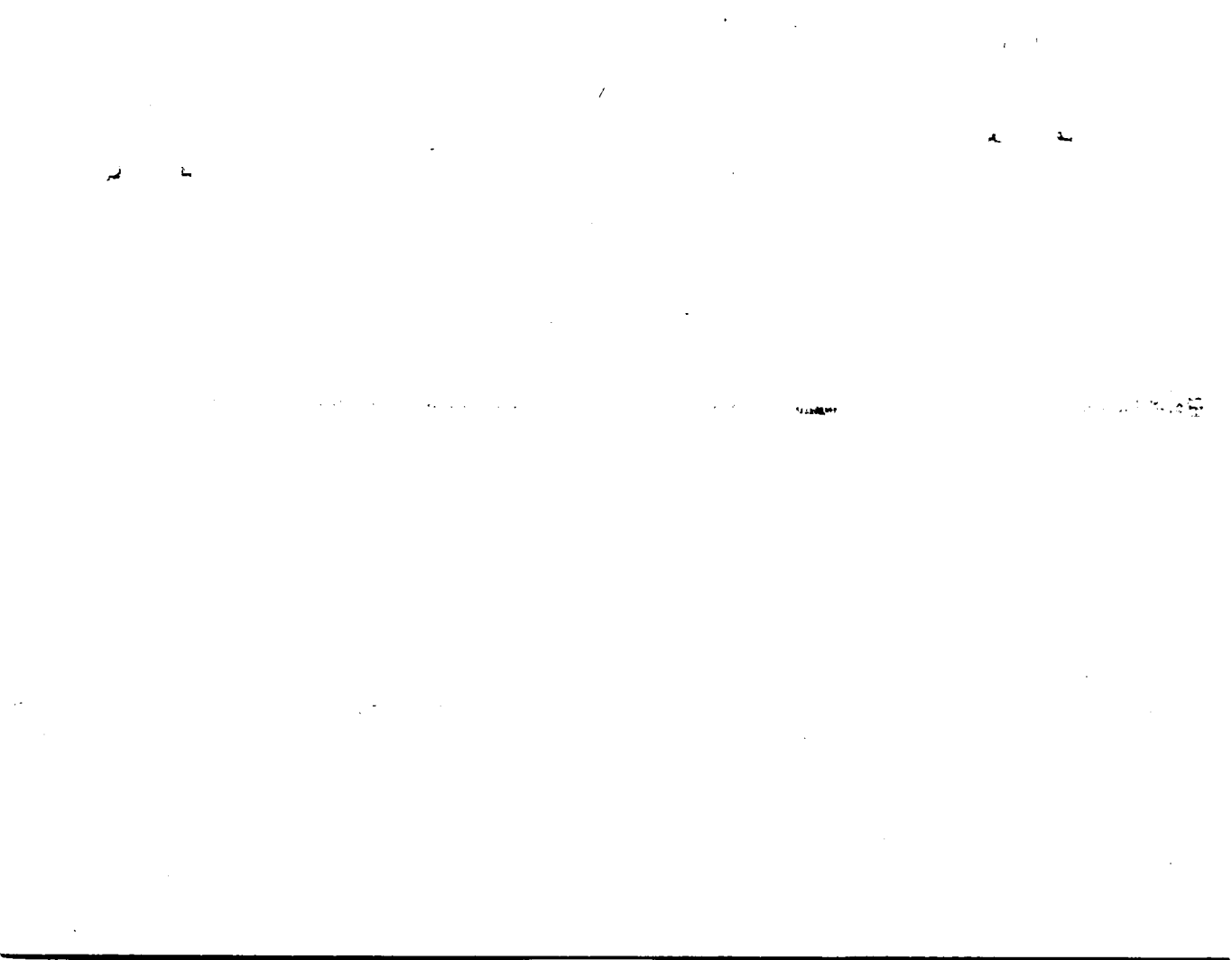
(Physician or midwife)

Address Winchester, Ida.

Filed 7/16 1929

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **65044**

County of Lewis
City of Winchester

Registration District No. 62
Primary Registration District No. 2119

Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still birth

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) 4 1/2 miles North of Winchester, Ida
(State or country)

10. NAME OF FATHER Charley Huntley

11. BIRTHPLACE OF FATHER (city or town) Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER Jamie Hilgers

13. BIRTHPLACE OF MOTHER (city or town) Demare, Kans
(State or Country)

14. Informant Jamie Hilgers
(Address) Winchester, Ida

15. Filed 7/6, 1929 P. O. Dureau
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born dead Jan 20 - 29
Feb 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I examined deceased born dead
Feb 14, 1929 to Body Feb 14, 1929
that I last saw her Body Feb 14, 1929
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Born dead

CONTRIBUTORY (Secondary) Still birth
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? St. Louis Length 14 in. M. D.
(Signed) Feb 14 1929 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

On Father's Ranch Jan 21 1929

20. Undertaker Address

Wm Hilgers Winchester Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

FEB 13 1929

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Madison
City of Replung R#3

CERTIFICATE OF BIRTH

S 168919

No. 433 St. 3-855

Registration District No. 100 State File No. 100

(If born in hospital or institution
give name.)

Prim. Registration District No. 2178 Local Registrar's No. 10

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>Jan. 8</u> (Month) (Day) (Year) <u>1929</u>
--------------------------	---	--------------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 8 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn 2

FATHER
FULL NAME Patric McCulloch

MOTHER
FULL MAIDEN NAME Mable Hendricks

Residence (Usual place of abode) Replung R#3

Residence (Usual place of abode) Replung #3

If nonresident, give place and State

If nonresident, give place and State

Color or race W Age at last Birthday 37
(Years)

Color or race W Age at last Birthday 38
(Years)

Birthplace Ida
(City and State or Country)

Birthplace Ida
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 6:00 P.M.
on the date above stated.

(Signature) H. B. Rigby M.D.

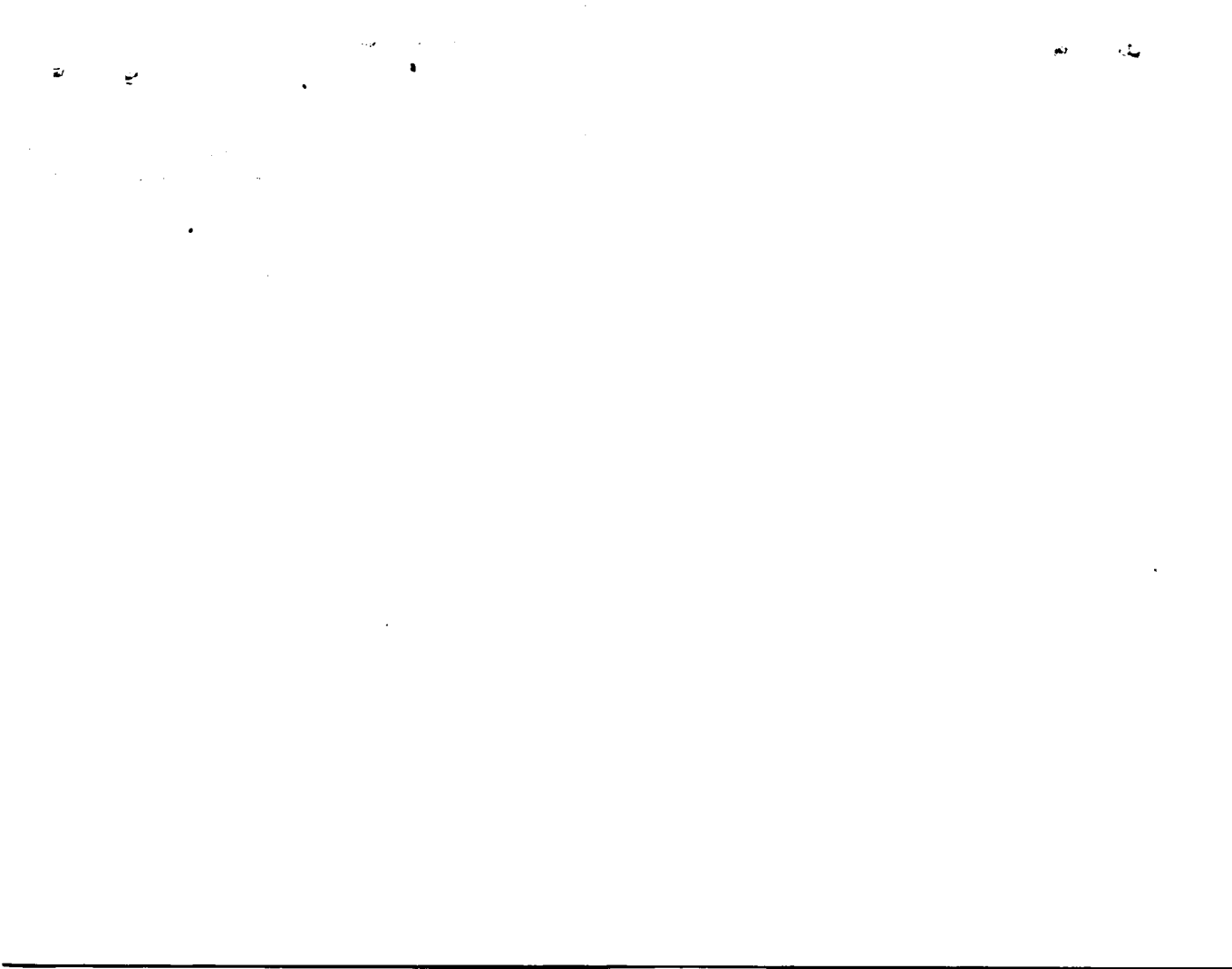
(Physician or midwife)

Address 219

Filed 2/9 1929 W. Young

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 13 1929

PLACE OF DEATH

County of MadisonCity of Replburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 100Primary Registration District No. 2178

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME none. Baby Mc. Culloch.

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day,
hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Pete McCulloch.11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho12. MAIDEN NAME OF MOTHER Mabel Hendrichs13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.14. Informant Pete Mc. Culloch. (Address)15. Filed 77, 1929 J. P. Young Registrar

DO NOT WRITE IN THIS SPACE

State File No. 65053Local Registrar's No. 4

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 8 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Delivered Jan 8, 1929, 19

that I last saw him alive on at 6:00 AM, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn (Premature
macerated fetus)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) W. B. Rigby M. D.Jan 8, 1929 (Address) Replburg, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Replburg 1920. Undertaker W. B. Ebersole Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

MAR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Oneida
City of Malden

No. St. Registration District No. 26 State File No. 168965

Hospital Primary Registration District No. 2169 Local Registrar's No. 21

FULL NAME OF CHILD Steve born

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>2-24</u> 192 <u>9</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Woyan Jan
RESIDENCE Malden Ida
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Malden Ida
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rose Harris
RESIDENCE Malden Ida
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Malden Ida
OCCUPATION Housewife

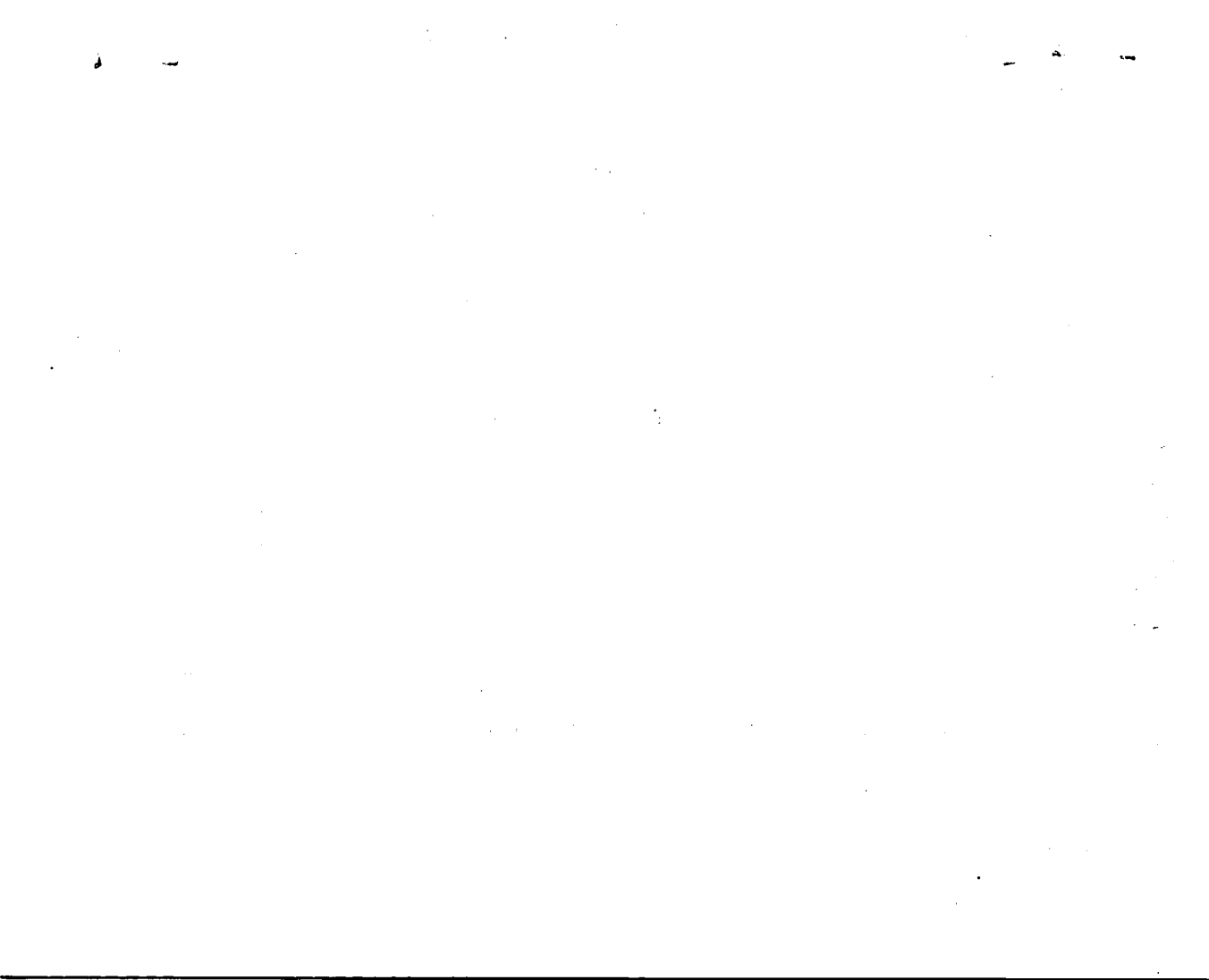
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 2 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 1929
Registrar.

(Signature) J. M. Harris
med.
(Physician or midwife)
Address Malden Ida
Filed 2/28 1929 J. M. Harris Registrar.



RECEIVED MAR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **65066**

PLACE OF DEATH
County of Ada
City of Malden Ida

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 2

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Stillborn St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.
at 5 mos.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Malden Ida
(State or country)

10. NAME OF FATHER Mayon T. Jones

11. BIRTHPLACE OF FATHER (city or town) Malden Ida
(State or Country)

12. MAIDEN NAME OF MOTHER Rose Harris

13. BIRTHPLACE OF MOTHER (city or town) Malden Ida
(State or Country)

Informant J. M. Keene(Address) Malden Ida

Filed 3/10/29 19 29 J. M. Keene
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 - 24 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-24 19 29 to 2-24 19 29
that I last saw him Stillborn

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. M. Keene M.D.Malden Ida 19 29 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Malden Ida 2-24 19 29

20. Undertaker

Address

None Malden Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as probably such, if impossible to termine definitely. Examples: Accidental drown' struck by railway train—accident; Revolver wound head—homicide; Poisoned by carbolic acid—probably cide. The nature of the injury, as fractured skull, and sequences (e. g. sepsis, tetanus) may be stated under head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician at the deceased and it is probable that death was due lawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical aid should be referred to the Health Officer (if any), but when there is no such health officer, in such cases, the local registrar may make the return the information of relatives or friends of the deceased, having adequate knowledge of the facts.

Do not accept a certificate of death signed by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

29 713 / 037 239
PLACE OF BIRTH
County of Payson MAR 6 1929 STATE OF IDAHO
City of New Plymouth DEPARTMENT OF PUBLIC WELFARE
No. R 302 St. BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 5 State File No. 168974
(If born in hospital or institution give name.) Prim. Registration District No. 2009 Local Registrar's No. 2

FULL NAME OF CHILD Herman Daniel Kitterman
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Jan 31</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate 1%

Number of child of this mother, including present birth 7 (a) Born alive and now living 5

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Henry Richard Kitterman</u>	MOTHER FULL MAIDEN NAME <u>Sylvia Strickland</u>
--	---

Residence (Usual place of abode) New Plymouth R. 2 Residence (Usual place of abode) with husband

If nonresident, give place and State _____ If nonresident, give place and State ✓

Color or race W Age at last Birthday 57 Color or race W Age at last Birthday 36
(Years) (Years)

Birthplace Kansas Birthplace Ill.
(City and State or Country) (City and State or Country)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5 a. M. on the date above stated.

(Signature) Wm J. Drysdale M.D.

(Physician or midwife)

Address New Plymouth Ida

Filed 7/23 1929 Wm J. Drysdale

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65067

County of Payette

City of New Plymouth
RFD 2

Registration District No. 5

Primary Registration District No. 2009

Local Registrar's No. 1

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Daniel Ketterman

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Stillborn

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Jan 31-1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) New Plymouth Ida
(State or country) RFD 2

10. NAME OF FATHER Henry Richard Ketterman

11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Sylvia Strickland

13. BIRTHPLACE OF MOTHER (city or town) Kan. Ill.
(State or Country)

14. Informant Wm J Drysdale
(Address)

15. Filed 2-23, 1929. Wm J Drysdale
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth, 19____, to____, 19____

that I last saw h____ alive on____, 19____

and that death occurred, on the date stated above, at____m.

The CAUSE OF DEATH* was as follows:

Large size of child & pro-
longed labor.

(duration) ____yrs. ____mos. ____ds.

CONTRIBUTORY
(Secondary)

(duration) ____yrs. ____mos. ____ds.

18. Where was disease contracted, if not at place of death? ✓

Did an operation precede death? ✓ Date of ____

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Wm J Drysdale, M. D.

2-13, 1929 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dick cemetery Date of Burial 2-1-1929

20. Undertaker Father of child Address New Plymouth Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Blaine **RECEIVED MAR 5 1929**
City of Tetonia

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. St.

391 212 041-168

(If born in hospital or institution give name.)

Registration District No. 77 State File No. 169028

Prim. Registration District No. 2176 Local Registrar's No. 3

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> (To be answered only in event of plural births)	and { Number in order of birth — (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>2 12 1928</u> (Month) (Day) (Year)
----------------------------	--	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% silver

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead None Stillborn None

FATHER FULL NAME <u>Wm J. Cravan</u>	MOTHER FULL MAIDEN NAME <u>Emma Mary Johnston</u>
---	--

Residence (Usual place of abode) Tetonia

If nonresident, give place and State

Color or race White Age at last Birthday 30 (Years)

Birthplace Idaho (City and State or Country)

Occupation Machine

FULL MAIDEN NAME Emma Mary Johnston

Residence (Usual place of abode) Tetonia

If nonresident, give place and State

Color or race White Age at last Birthday 20 (Years)

Birthplace Marionville, Mo. (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 6:15 PM on the date above stated.

(Signature) W. J. Parkinson

(Physician or midwife)

Address Driggs, Ida.

Filed 3-1-1929 Martha Marker

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

20

21

22

PLACE OF DEATH

County of Teton
City of Teton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 77
Primary Registration District No. 2176

DO NOT WRITE IN THIS SPACE

State File No. 65080Local Registrar's No. 5

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Infant Stillborn

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) _____

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Feb 12 - 1929

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Idaho
(State or country)

10. NAME OF FATHER Wm J. Branner

11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Edna May Johnston

13. BIRTHPLACE OF MOTHER (city or town) Ida.
(State or Country)

14. Informant Wm J. Branner
(Address) Teton, Ida.

15. Filed 2-28- 1939 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to 2-12- 1929
that I last saw h. on 2-12- 1929

and that death occurred, on the date stated above, at Teton, Ida.

The CAUSE OF DEATH* was as follows:

Malnutrition
(monstrous)
_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. J. Parkinson M. D.2-12- 1929 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Teton, Idaho Date of Burial 2-13- 1929

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

64768
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

613-2114 042-895
PLACE OF BIRTH
County of Linn
City of Linn Falls

MAR 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

Linn Falls Co. Hosp.
(If born in hospital or institution give name.)

Registration District No. 39 State File No. 169070

Prim. Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth 1 14 1929 (Month) (Day) (Year)
--------------------------	---	-----	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Hugh E. Wallace</u>	MOTHER FULL MAIDEN NAME <u>Lillian Hines</u>
--	---

Residence (Usual place of abode) 946 Blue Lake Blvd.

If nonresident, give place and State _____

Color or race white Age at last Birthday 29 (Years)

Birthplace Oxford, Mississippi

Occupation Electrician

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 25 30 P. M.
on the date above stated.

(Signature) J. E. Lamb

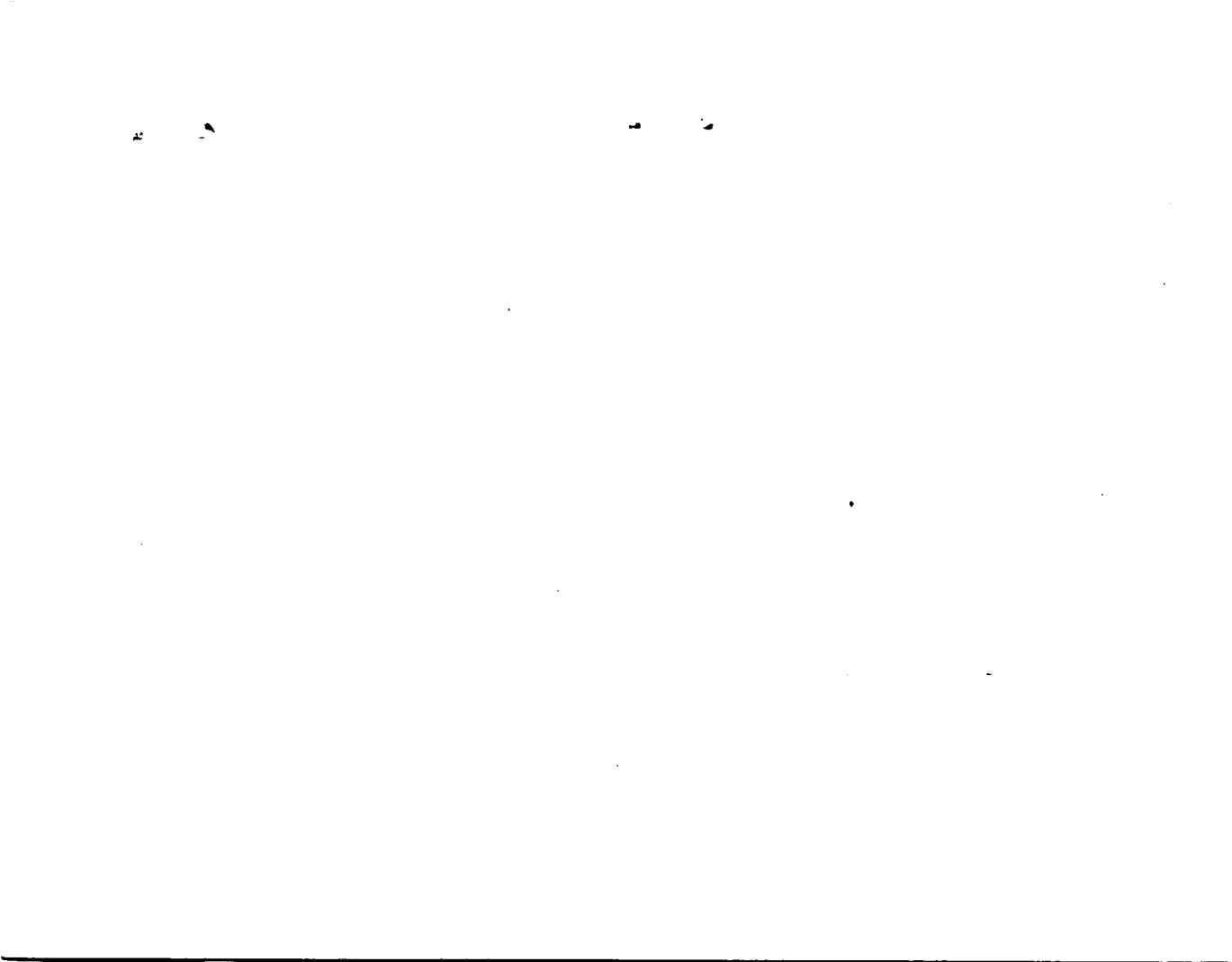
(Physician or midwife)

Address Linn Falls Ida

Filed 3-10-1929 A. T. Leet

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64768

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. _____

Primary Registration District No. 100

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

2. FULL NAME William Hines Wallace

(a) Residence. No. 946 - Blue Lakes Ave St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

Jan 14 - 1929

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Twin Falls

10. NAME OF FATHER

Hugh E. Wallace

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Miss

12. MAIDEN NAME OF MOTHER

Lillian Hines

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Miss

14.

Informant

(Address)

Hugh E. Wallace

946 - Blue Lakes Ave

15.

Filled

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14, 1929, to Jan 14, 1929

that I last saw him alive on Jan 14, 1929

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia intra uterine.
6 mos development

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Eclampsia in mother

(duration) yrs. mos. ds.

18. Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 1-14-29

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. S. Hines M. D.

19. (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls Cemetery

Jan 16 1929

20. Undertaker

Address

White Mortuary

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of **RECEIVED**
City of

MAR 5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

169096

No. St.

997-213-042473

(If born in hospital or institution
give name.)

Registration District No. State File No.

Prim. Registration District No. **2087** Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child F	Twin Triplet or other? 1	and	Number in order of birth 1	Legiti- mate? Yes	Date of birth 12-Feb- (Month) (Day) (Year) 1929
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? **0**

Number of child of this mother, including present birth **1** (a) Born alive and now living **0**

Born alive but now dead **1** Stillborn **1**

FATHER
FULL NAME **Oren Riggs**

Residence (Usual place of abode) **Buhl, Ida.**

If nonresident, give place and State

Color or race **White** Age at last Birthday **25**
(Years)

Birthplace **Franklin, Indiana**
(City and State or Country)

Occupation **farming**

MOTHER
FULL MAIDEN NAME **Edna Miller**

Residence (Usual place of abode) **Buhl, Ida.**

If nonresident, give place and State

Color or race **White** Age at last Birthday **20**
(Years)

Birthplace **Hedrick, Colorado**
(City and State or Country)

Occupation **housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was **Born** at **6:30** A.M.
on the date above stated.

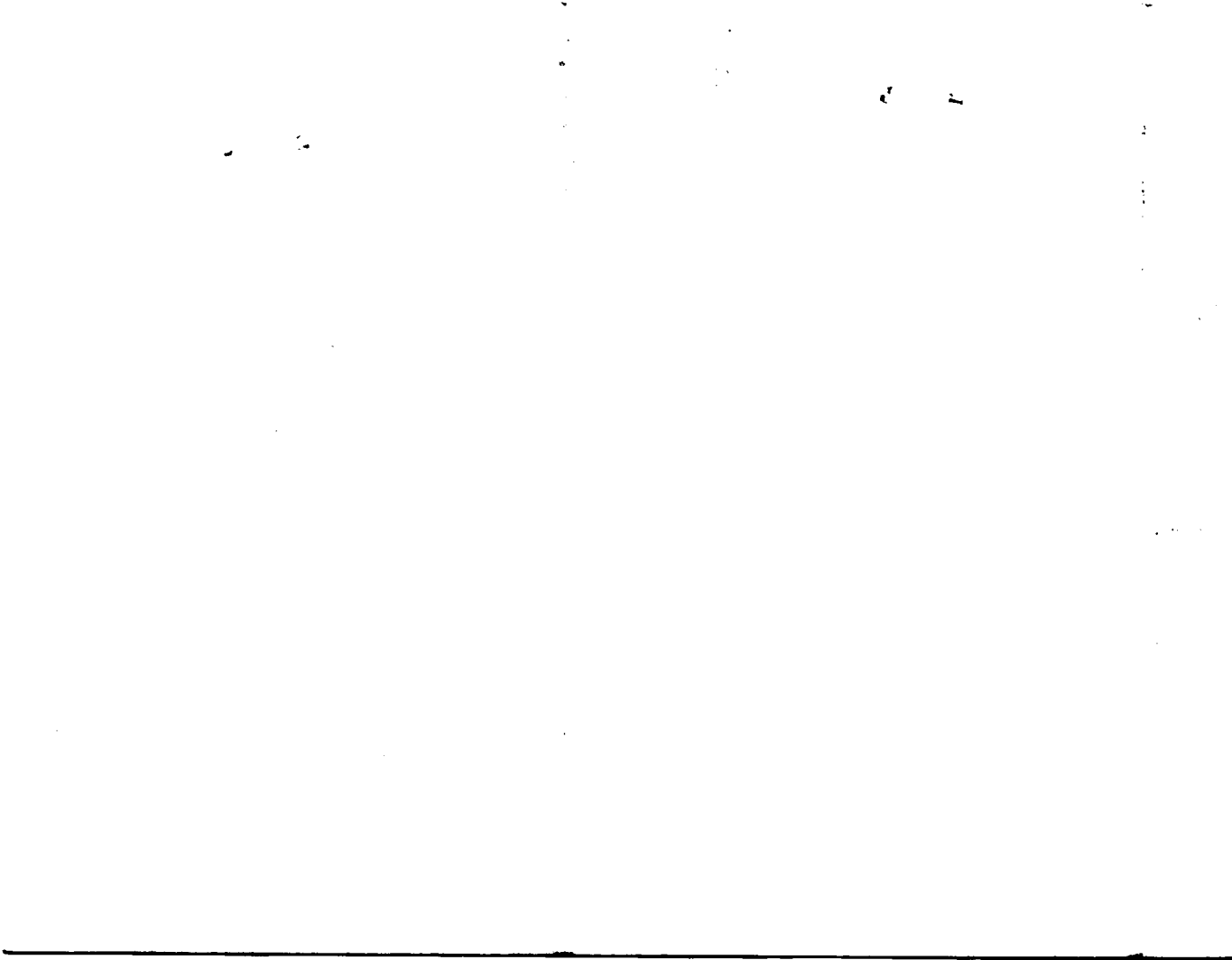
(Signature) **J. W. Mac Manus**

(Physician or midwife)

Address **Buhl, Idaho**

Filed **2-15** 1929 **J. H. Wurfel**
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED MAR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **65087**

PLACE OF DEATH

County of Latah
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Stillborn (Riggs)

(a) Residence. No.

St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write, the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>✓</u>		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years <u>0</u> Months <u>0</u> Days <u>0</u>	If LESS than 1 day, <u>0</u> hrs. or <u>0</u> min.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Buhl, Ida.

10. NAME OF FATHER

O. D. Riggs

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Franklin, Indiana

12. MAIDEN NAME OF MOTHER

Edna Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Colorado

14.

Informant O. D. Riggs
(Address) Buhl, Ida.

15.

Filed 2-13, 1929

J. H. Murphy
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Stillborn, 1929

that I last saw him alive on _____, 1929

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Craniotomy
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Maxman, M. D.

13-Feb-1929 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Buhl, Ida. 2-14 1929

20. Undertaker

Address

D. Johnson Buhl, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

759-224 044-326
PLACE OF BIRTH RECEIVED

MAR 1 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Washington

City of Winn

No. _____ St. _____

Registration District No. 56

File No. 169129

Hospital _____

Primary Registration District No. 2112

Registered No. 15

FULL NAME OF CHILD Melba Reiber

(Certificate of no value without full name of child.)

Sex of Child <u>girl</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>Jan/24/1929</u> (Month) (Day) (Year)
--------------------------	------------------------------------	-----	--------------------------------------	-----------------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Arthur John Reiber
RESIDENCE Winn
COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Oregon
OCCUPATION rancher

MOTHER
FULL MAIDEN NAME Alta May Lyman
RESIDENCE Winn
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Idaho
OCCUPATION home wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

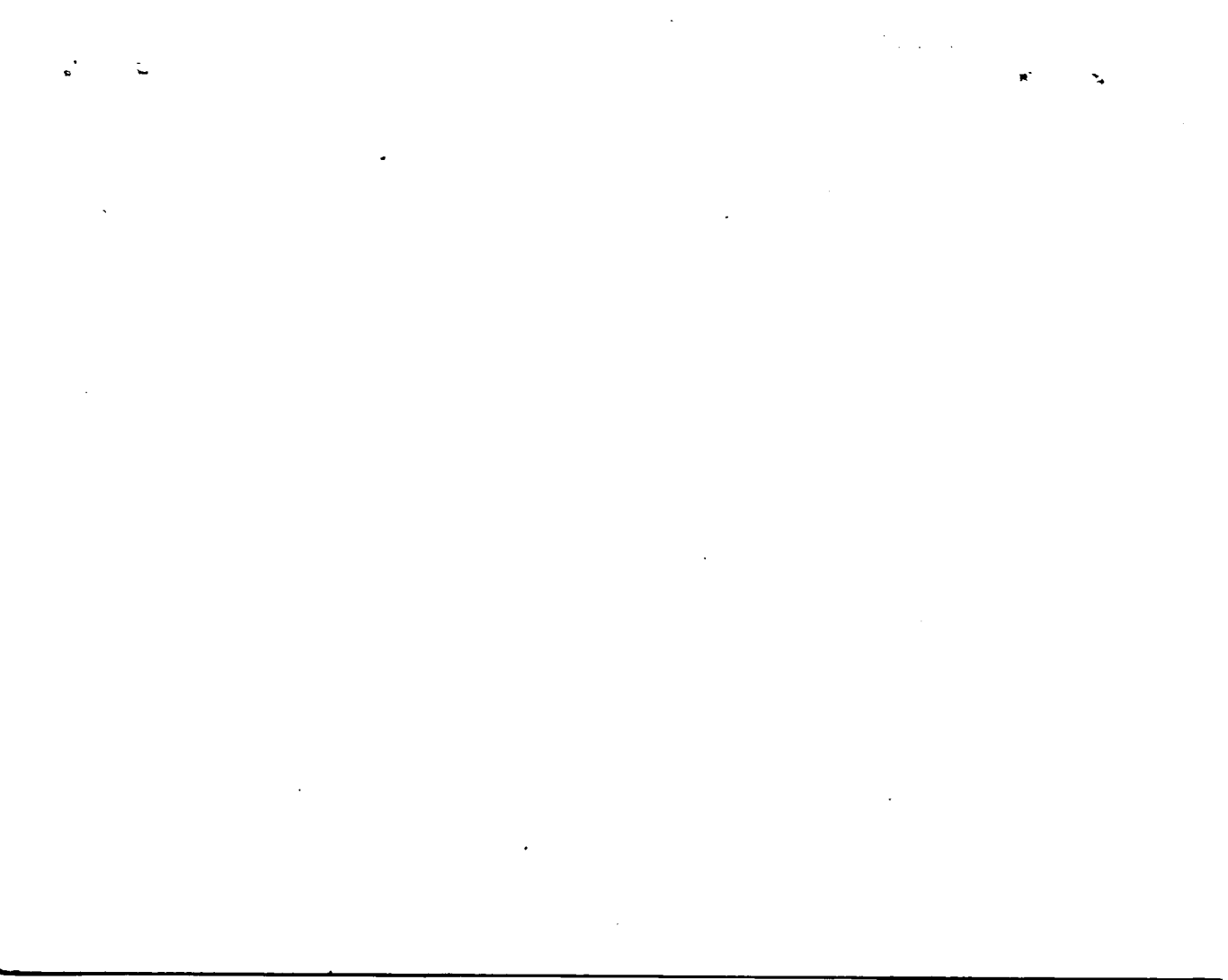
(Signature) F. A. Schmidt, M.D.

(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address Winn Idaho
Filed Feb 29 1929 M. B. Hamilton
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 1 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65124

PLACE OF DEATH

County of Washington
City of Weiser

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1016

Local Registrar's No. 11

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Milla Reiser

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE Wh 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24-1929

7. AGE Years Months Days If LESS than 1 day. hrs. or min.
- 2 weeks

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Weiser Idaho
(State or country)

10. NAME OF FATHER Arthur J. Reiser

11. BIRTHPLACE OF FATHER (city or town) Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER ella May Lyons

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Dr F.A. Schmitz
(Address) Weiser Idaho

15. Filed Feb 10, 1929 W. A. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 24-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24-1929, to Jan 24-1929
that I last saw h. alive on Jan 24-1929, 19
and that death occurred, on the date stated above, at still born m.
The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.
CONTRIBUTORY Card ruptured aorta
(Secondary) met
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. A. Schmitz, M. D.
Jan 24-1929 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sevier County Date of Burial 1-25 1929

20. Undertaker L. C. Northman Address Weiser Idaho

Man has the word the card as a club.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

3614 204-687-689
PLACE OF BIRTH RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

169337

County of Laramie
City of Laramie
No. 500 St. Hwy

CERTIFICATE OF BIRTH

Registration District No. 57 State File No. 14
Prim. Registration District No. 2075 Local Registrar's No. 14

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legiti- mat Date of birth 2 4 19 29
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Derald Harry Lumsden
Residence (Usual place of abode) Richfield, Id.
If nonresident, give place and State _____
Color or race White Age at last Birthday 29
Birthplace Clinton, Iowa (Years)
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Oliver White
Residence (Usual place of abode) Richfield, Id.
If nonresident, give place and State _____
Color or race White Age at last Birthday 19
Birthplace Clinton, Id. (Years)
(City and State or Country)
Occupation Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 10 P.

(Signature) [Signature]
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Mailbox 204
Filed 3-1 19 29 Phat H. Wright
Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

65220

State File No.

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 814

2. FULL NAME

(a) Residence. No. Richfield, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or country)14. Informant
(Address)

15. Filed

3 - 31, 1929

Robert H. Wright

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1929
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19

, to

, 19

that I last saw him alive on

, 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Self born. Prolapsed cord

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

1929 (Address)

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Richfield, Ida2-5 1929

20. Undertaker

Address

Harris + AmosHailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Boise **RECEIVED APR 6 1929**
City of Sandpoint

No. St.

381719 009 314

(If born in hospital or institution give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 169355**

Registration District No. 76 State File No.

Prim. Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD Ananda

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and }	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth	<u>3</u>	<u>19</u>	<u>1929</u>
					(Month)	(Day)	(Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead Stillborn 3

FATHER FULL NAME <u>Harry Chamberlain</u>	MOTHER FULL MAIDEN NAME <u>Maud Lady</u>
--	---

Residence (Usual place of abode) Sandpoint

If nonresident, give place and State

Color or race White Age at last Birthday 42 (Years)

Birthplace Iowa (City and State or Country)

Occupation Laborer

Residence (Usual place of abode) Sandpoint

If nonresident, give place and State

Color or race White Age at last Birthday 29 (Years)

Birthplace Michigan (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 5:30 A.M.
on the date above stated.

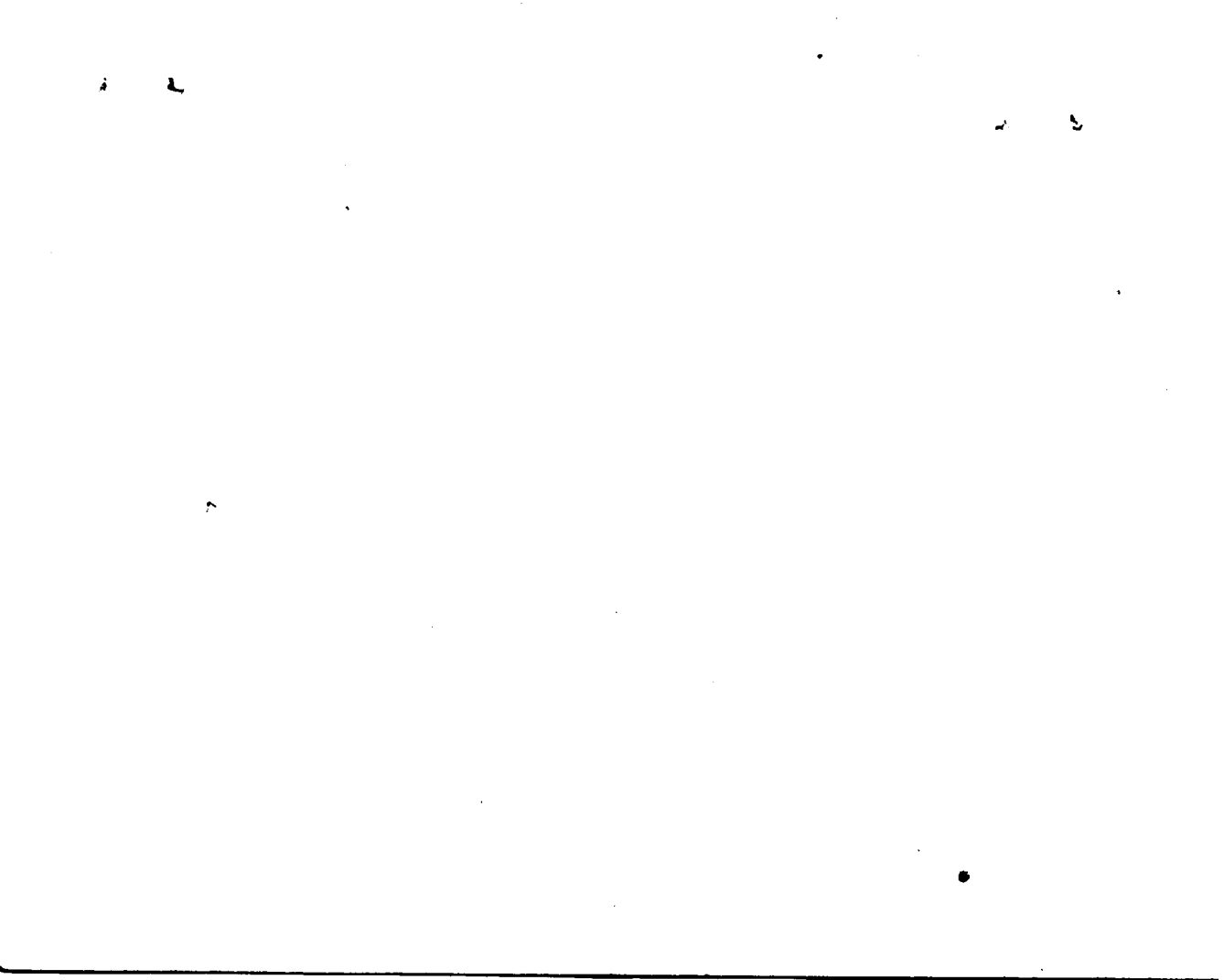
(Signature) L. E. Elsworth M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Sandpoint, Ida.

Filed April 23 1929 Viola Allen
Deputy Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1929

PLACE OF DEATH

County of BonnerCity of SandpointSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155

DO NOT WRITE IN THIS SPACE

State File No. 65231

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Infant Chamberlain

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single Married, Widowed,
or Divorced (write the word)Male White5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) March 17, 19297. AGE Years Months Days If LESS than 1 day,
Stillborn hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint Ida
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant Harry Chamberlain
(Address) Sandpoint Ida.15. Filed March 29, 1929 Lila Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____.

that I last saw him alive on Stillborn, 19____.and that death occurred, on the date stated above, at Refectory m.

The CAUSE OF DEATH* was as follows:

7 months gestation
Breach presentation &
Difficult Labor
(duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY Lambed Kary
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) L. E. Allen, M. D.
3-27, 1929 (Address) Sandpoint*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pinecrest CemeteryMarch 30 1929

20. Undertaker

MOON MORTUARY

Address

SANDPOINT IDAHO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED ^{249-117 010-296} RECEIVED MAR 21 1929

County of Bannockville
City of Idaho Falls, Idaho
No. Boulevard et Cal St.

Spencer Hospital
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

169383

Registration District No. 73 State File No. _____

Prim. Registration District No. 2 Local Registrar's No. 20

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth }	Legitimate? <u>yes</u>	Date of birth <u>February 17</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME James William Burges

MOTHER
FULL MAIDEN NAME Susan Estella Bilsman

Residence (Usual place of abode) Swan Valley, Idaho

Residence (Usual place of abode) Swan Valley, Idaho

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 22
(Years)

Color or race White Age at last Birthday 23
(Years)

Birthplace Minneapolis, Oklahoma
(City and State or Country)

Birthplace Coeur d'Alene, Idaho
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 30 PM on the date above stated.

(Signature) [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or Midwife)
Address Idaho Falls, Ida

Filed 2/27 1929 Alfred
Registrar.

201

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAR 21 1929

PLACE OF BIRTH

County of Bonneville

City of Idaho Falls

No. 53-221-010-294 St.

L. D. S.

(If born in hospital or institution give name.)

Registration District No. 73 State File No. S 169388

Prim. Registration District No. 2-4-2 Local Registrar's No. 72

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 21</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead 1 Stillborn 1

FATHER

FULL NAME Lester, H. Peterson

Residence (Usual place of abode) Ucon, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 35 (Years)

Birthplace Hyrum, Utah (City and State or Country)

Occupation Mechanic

MOTHER

FULL MAIDEN NAME Nellie Ray Simmons

Residence (Usual place of abode) Ucon, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 34 (Years)

Birthplace Ucon, Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:45 2 . M.
on the date above stated.

(Signature) [Signature]

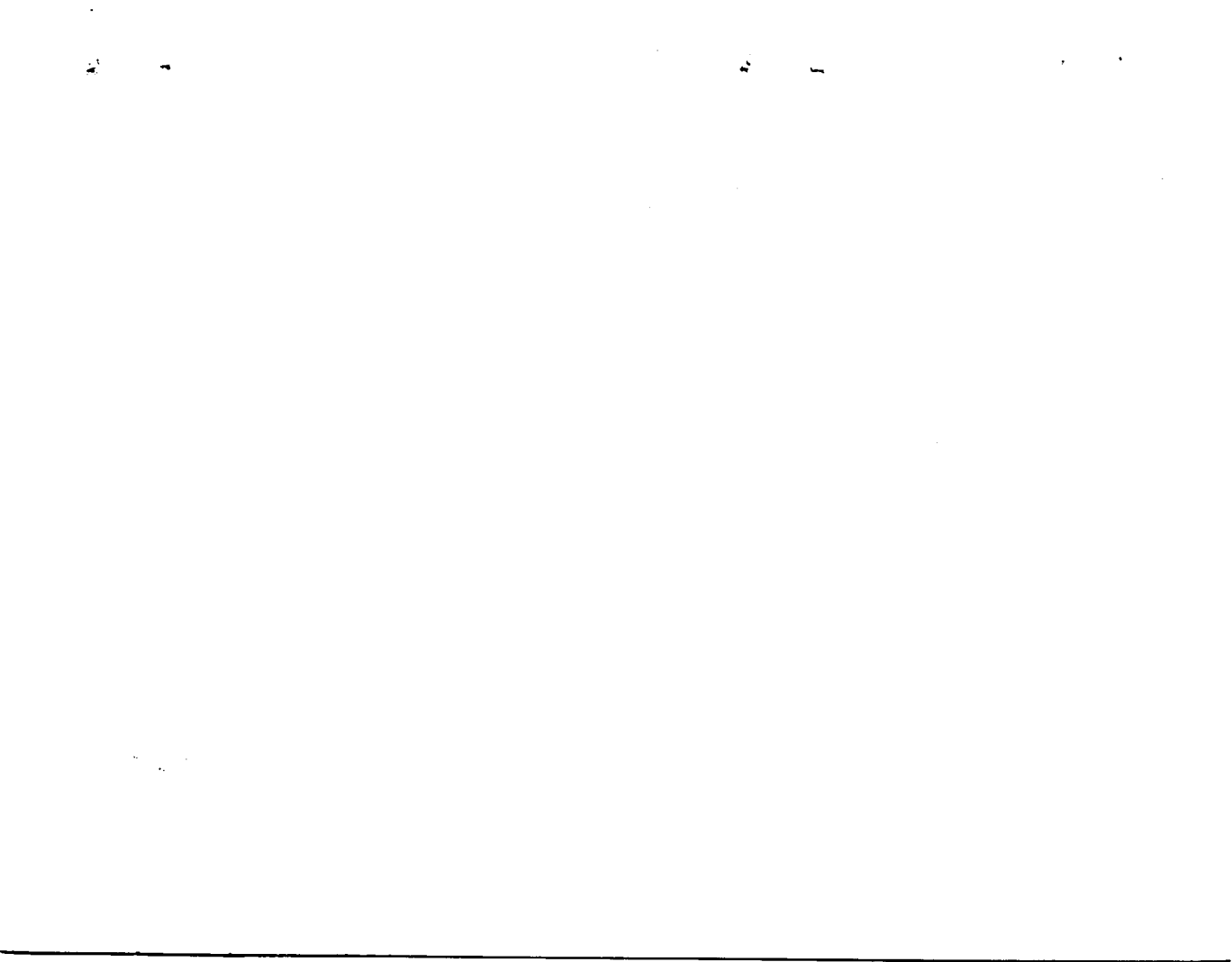
(Physician or midwife)

Address [Signature]

Filed 73 1929 [Signature]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 214-0

(No. St.)

2. FULL NAME

Still Born

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 65248

Local Registrar's No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white

Infant
(Write the word)

6. DATE OF BIRTH

February 20 1929
(Month) (Day) (Year)

7. AGE

Premature 7 1/2 mo long hrs. or min.?
Yrs. Mos. ds.

IF LESS than 1 day how many

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls, Ida

10. NAME OF

Father Lester H. Peterson

11. BIRTHPLACE

OF FATHER Hyrum, Utah
(State or Country)

12. MAIDEN NAME

OF MOTHER Nellie May Simmons

13. BIRTHPLACE

OF MOTHER near Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester H. Peterson
(Address) Idaho Falls, Ida

15.

Filed

7/21 1929 Jefferson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21st 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1929 to Feb 20 1929
that I last saw him alive on Feb 20 1929

and that death occurred on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:

Shock of mother
(sudden fright due to)
house on fire

(Duration) yrs. mos. 10 ds.

Contributory

(Secondary) Death in labor
Disinfectant
(Duration) yrs. mos. 3 ds.

(Signed)

7/21 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? near

Former or usual residence near Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Feb 21 1929

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bonneville
City of Idaho Falls

No. 172-197 St.

764-200010-464
(If born in hospital or institution give name.)

RECEIVED
MAR 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

115-3
S 169414

Registration District No. 73 State File No. _____

Prim. Registration District No. 2150 Local Registrar's No. 44

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate <u>Yes</u>	Date of birth <u>Feb. 3</u> (Month) (Day) (Year) <u>19 29</u>
----------------------------	---	-----	--------------------------------	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 8
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Carl Gould
Residence (Usual place of abode) Idaho Falls, Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 38 (Years)
Birthplace Buffalo, Kan.
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Mabel Dodson
Residence (Usual place of abode) Idaho Falls, Ida.
If nonresident, give place and State _____
Color or race White Age at last Birthday 35 (Years)
Birthplace Hill City, S. Dak.
(City and State or Country)
Occupation Housewife

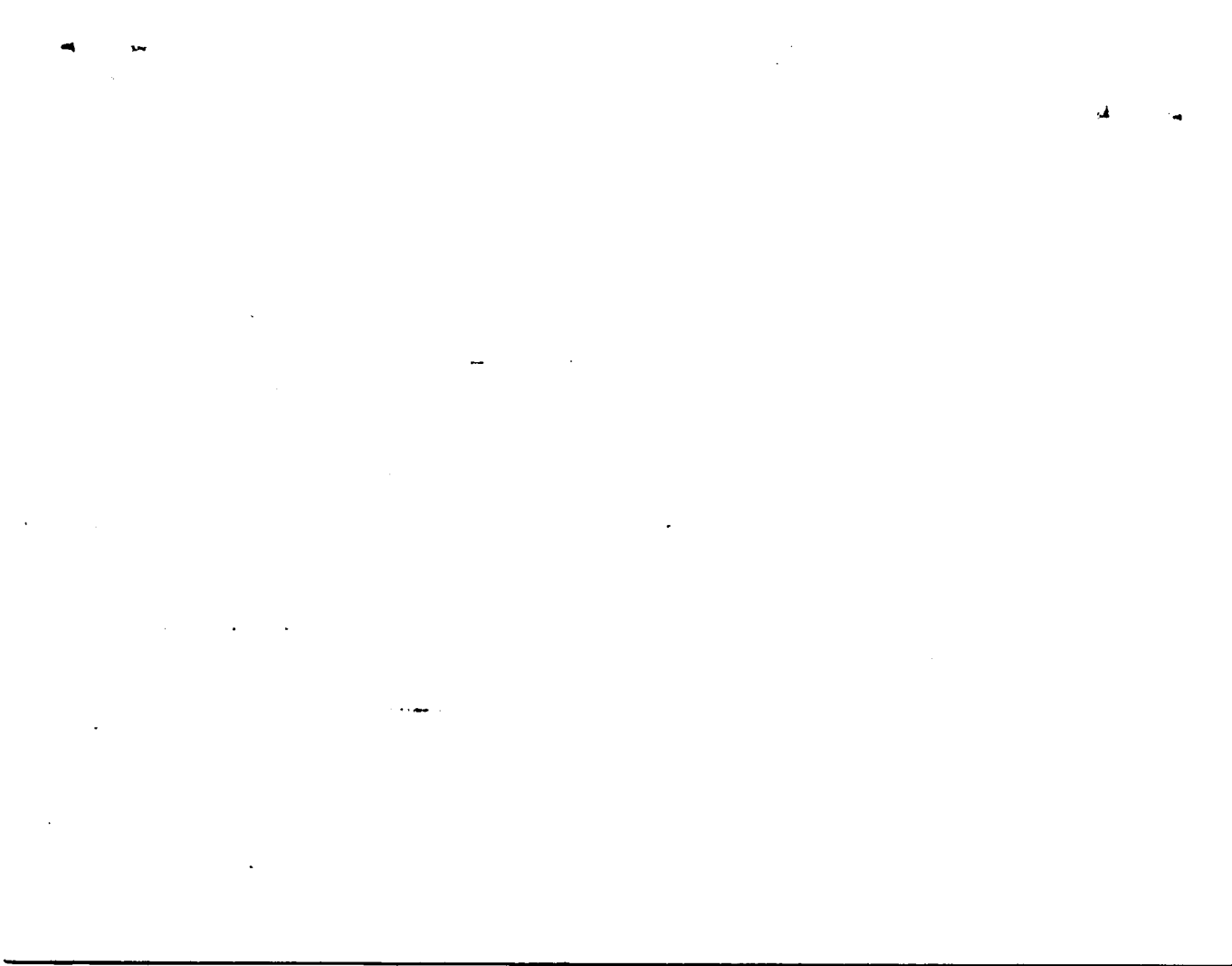
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4.30 P. M.
on the date above stated.

(Signature) [Signature]
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho Falls, Idaho.
Filed Oct 4 19 29 [Signature]
Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65264

County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 215-0

Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Gould

(a) Residence. No. 192 W 19th St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Born Dead

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country) ID

10. NAME OF FATHER Carl Gould

11. BIRTHPLACE OF FATHER (city or town) Romney (State or Country)

12. MAIDEN NAME OF MOTHER Mable Hodson

13. BIRTHPLACE OF MOTHER (city or town) North Platte (State or Country)

14. Informant Carl Gould (Address) Idaho Falls Idaho

15. Filed Feb 11, 1929 W. J. Fanning Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to Feb 3, 1929
that I last saw her alive on Feb 2, 1929

and that death occurred, on the date stated above, at no m.
The CAUSE OF DEATH* was as follows:

Still birth - due to premature separation placenta
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Fanning M. D. 215-0, 1929 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Date of Burial Feb 5 1929

20. Undertaker Chas. J. Hayes Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Caldwell **RECEIVED APR 9 1929**
City of Caldwell
No. 318 121 014 318 St. Registration District No. 3 State File No. 169427

Hospital _____ Primary Registration District No. 1005 Local Registrar's No. 52

FULL NAME OF CHILD Waylor
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>May-21-1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Phymer J Taylor</u>	FULL MAIDEN NAME	<u>Larrie Taylor</u>
RESIDENCE	<u>Caldwell Ida</u>	RESIDENCE	<u>Caldwell</u>
COLOR	<u>White</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>21</u> (Years)	AGE AT LAST BIRTHDAY	<u>16</u> (Years)
BIRTHPLACE	<u>Landon Ky.</u>	BIRTHPLACE	<u>Mo</u>
OCCUPATION	<u>Truck Driver</u>	OCCUPATION	<u>H.W.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive / Stillborn } at 2 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192____

(Signature) [Signature]

(Physician or midwife)
Address Caldwell Idaho

Filed 3-22-1929
Registrar. John S. Meyers
Registrar.

[illegible]

HTF 10-35A-14

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CONTENTS OF BOOK

to 77.100)

GM

1814-1815

PLUMB TO MEAT MEAT

10 222
b1110

The above is a list of the names of the persons who have been
 appointed to the various positions in the Department of the
 Interior, and who have been assigned to the various divisions
 of the Department. The names are given in alphabetical order,
 and the positions are given in the order in which they are
 listed in the Department.

What bacterial solution was used in 1961?

Number of child of this number, including present birth

[illegible]

FATHER

1107
5 MAY

904241E2

REFERENCE

RD 200

NO. 100

AGE AT LAST
YACHTING

YACHTING

PLATE 1

RECEIVED

MOBILE 440550

OCCLUSION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that the data above stated.

When there was no attending physician or midwife, then the father, nonprofessional, should make the return. A midwife, if she is the attending physician, not a midwife, is the attending physician. It shows other evidence of the situation. It shows other evidence of the situation. It shows other evidence of the situation.

(97-1447-10)

(b) (5) DPP, (b) (5) ACP

2257 161.

291

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 8. 12-1/2 M. 7-24-11 RECEIVED APR 9 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. _____, St.)

File No. 65297
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby
Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Mar 21 1929
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day
yrs. mos. ds. how many 0 hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Caldwell Ida

10. NAME OF FATHER Olmes J Taylor

11. BIRTHPLACE OF FATHER (State or Country) London Ky

12. MAIDEN NAME OF MOTHER Laric Smysers

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Olmes J Taylor
(Address) Caldwell Ida

15. Filed 3-22-1929 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 21 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1929, to Mar 21 1929
that I last saw Still Born 191
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Meyer M. D.
3/21/29 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Middleton Idaho March 22 1929

20. UNDERTAKER ADDRESS
C. H. Peckham Caldwell Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Canyon RECEIVED APR 9 1929
City of Caldwell
No. 416-220-214-165 St. Registration District No. 3 State File No. 169428
Hospital _____ Primary Registration District No. 2005 Local Registrar's No. 51
FULL NAME OF CHILD Dawson

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth Mar 20 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? NoNumber of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Wm Dawson
RESIDENCE Caldwell Ida
COLOR White AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Butler Mo-
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Pearl Jones
RESIDENCE Caldwell Ida
COLOR White AGE AT LAST BIRTHDAY 21
(Years)
BIRTHPLACE Mo-
OCCUPATION H.V.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 11 30 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. D. Farrer

(Physician or midwife)

Address Caldwell IdaFiled 3-21- 1929

Registrar.

Registrar.

to view
to view

WHERE TO STAY

Primo, 100 Station District No. 100, Local R-4, District No. 100.

18792011

PLATE 40 MAY 1971

15. It is not possible to have a person who is not a person.

[illegible]

What practical solution was used in 1982?

Number of child in this method was custom aid to child to reduce

ЯЗНТОН

FIGHTA

✓ 301 AM
BMA

CONFIDENTIAL

AGE AT LAST
BIRTHDAY

80-20

TRAJTA DDA
AONTNIB

CC-015

REF ID: A67408

22A.14HTNIB

401745

NOTATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of said child, who was born at

*When there was no remaining explanation or relative then the former board member was interviewed by the FBI.

The following are the names of the other witnesses who were interviewed:

The names added from a supplemental report.

Physician or midwife)

49101

75712403

[illegible]

RECEIVED APR 9 1929

PLACE OF DEATH

County of

City of

Canyon
Caldwell

Registration District No.

Primary Registration District No.

(No. _____)
(If death occurred in a hospital or institution give its name instead of street and number.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65299

Local Registrar's No. 21

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)

Female white Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14.

Informant

(Address)

15.

Filed

3-20-1929

John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 20, 1929, to Mar 20, 1929
that I last saw him alive on Still Born, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. J. Garver M. D.

Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

at Home.

3-20-1929

20. Undertaker

Address

Father and Friends, Caldwell
Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 8 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 169528

County of Franklin
City of Preston
No. St.

253717021551

(If born in hospital or institution
give name.)

Registration District No. 27 State File No.

Prim. Registration District No. 2119 Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Mar 17</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead Stillborn Stillborn

FATHER
FULL NAME Norman E. Kelley

Residence (Usual place of abode) Preston Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 38 (Years)

Birthplace Marsh Creek Ida.
(City and State or Country)

Occupation Farmville

MOTHER
FULL MAIDEN NAME Mary Evans

Residence (Usual place of abode) Preston, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 32 (Years)

Birthplace Mary Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 4 30 P M.
on the date above stated.

(Signature) Ed. Veale

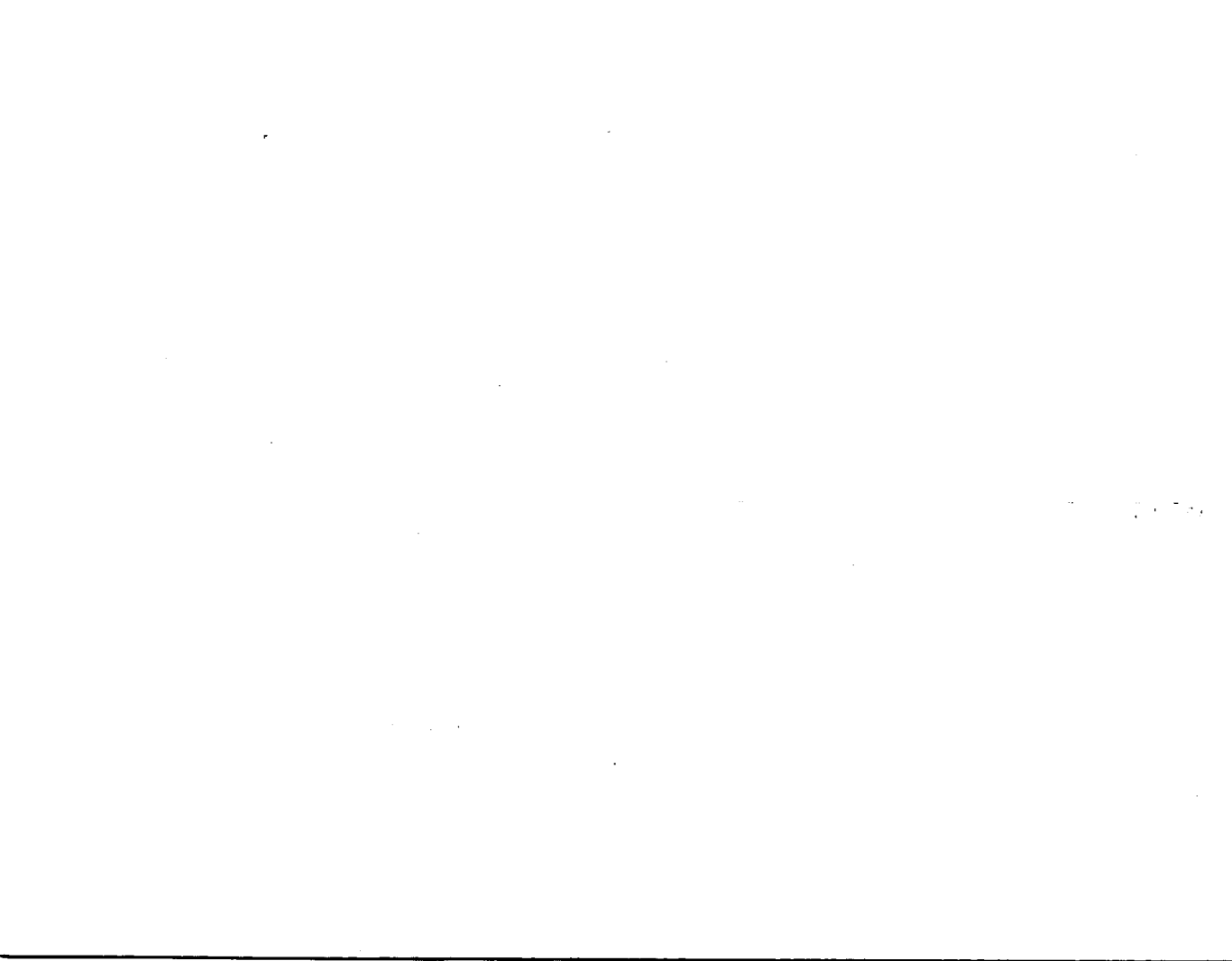
Physician
(Physician or midwife)

Address Preston Idaho

Filed 19 Ed. Veale

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

815 223 012 264
PLACE OF BIRTH

RECEIVED MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Fremont

City of Ashton

No. _____ St. _____

Registration District No. 102

File No. 169540

Hospital _____

Primary Registration District No. 6

Registered No. _____

FULL NAME OF CHILD

Stillborn

Hanni

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>2-23-29</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER C. R. Hanni

FULL MAIDEN NAME MOTHER Elma Smith Hanni

RESIDENCE Ashton, Idaho

RESIDENCE Ashton, Idaho

COLOR white AGE AT LAST BIRTHDAY 22 (Years)

COLOR white AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Idaho

BIRTHPLACE Utah

OCCUPATION Labarier

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:00 P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. M. C. Hanni

(Physician or midwife)

Give names added from a supplemental report.

Address Ashton, Idaho

Filed 2-23-29 C. M. C. Hanni

Registrar.

Registrar.

NO 7

NO 7

CHAD TO

CERTIFICATE OF BIRTH

.....laigeoH

FULL NAME OF CHILD

State of Texas, now and then labeled and W

100-443887-100

SECRET

RESIDUAL

~~SECRET~~

10-10-68

[illegible]

10-10-68

CERTIFICATE OF ADEQUACY

I hereby certify that I attended the birth of this child, who was
on the date above stated.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

.....

100-443887-100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED ADD 1-2-1929		STATE OF IDAHO	
County of <u>Booneville</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Ucon</u>		BUREAU OF VITAL STATISTICS	
APR 12 1929			
CERTIFICATE OF BIRTH			
No. <u>239103 00-799</u>		St. <u> </u>	
(If born in hospital or institution give name.)		Registration District No. <u>98</u> State File No. <u>169605</u>	
Prim. Registration District No. <u>2176</u>		Local Registrar's No. <u>58</u>	
FULL NAME OF CHILD <u>Premature Stillborn</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? <u>✓</u>	and { Number in order of birth <u>✓</u>	Legitimate <u>Yes</u>
(To be answered only in event of plural births)		Date of birth <u>Nov. 2</u> 19 <u>29</u>	(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>0.2% ZnSO4</u>			
Number of child of this mother, including present birth <u>5</u> (a) Born alive and now living <u>0</u>			
Born alive but now dead <u>1</u>		Stillborn <u>4</u>	
FATHER FULL NAME <u>Charles F. Russell</u>		MOTHER FULL MAIDEN NAME <u>Beatrice Chise</u>	
Residence (Usual place of abode) <u>Ucon</u>		Residence (Usual place of abode) <u>Ucon</u>	
If nonresident, give place and State <u> </u>		If nonresident, give place and State <u> </u>	
Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)		Color or race <u>White</u> Age at last Birthday <u>30</u> (Years)	
Birthplace <u>Utah</u> (City and State or Country)		Birthplace <u>Utah</u> (City and State or Country)	
Occupation <u>Farmer</u>		Occupation <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8:45 P.M.
on the date above stated. Stillborn

(Signature) N. R. West

Thel
(Physician or midwife)

Address Regis. John

Filed 4-1 1929 Ch. J. J. J.

Registrar.

S

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

25571 KOD 247

County of KootenaiCity of Coeur d'Alene

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. 169652 St. Registration District No. 30 State File No. 169652Hospital _____ Primary Registration District No. 1051 Local Registrar's No. 50FULL NAME OF CHILD Lawrence Arnold Seedy

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>2</u> <u>11</u> <u>1929</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Jesse Abner Seedy</u>	<u>Coeur d'Alene Idaho</u>	<u>Violet Daisy Keger</u>	<u>Coeur d'Alene Ida</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Roland Iowa</u>		BIRTHPLACE <u>Gibbon Minn</u>	
OCCUPATION <u>Teamster</u>		OCCUPATION <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 30 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

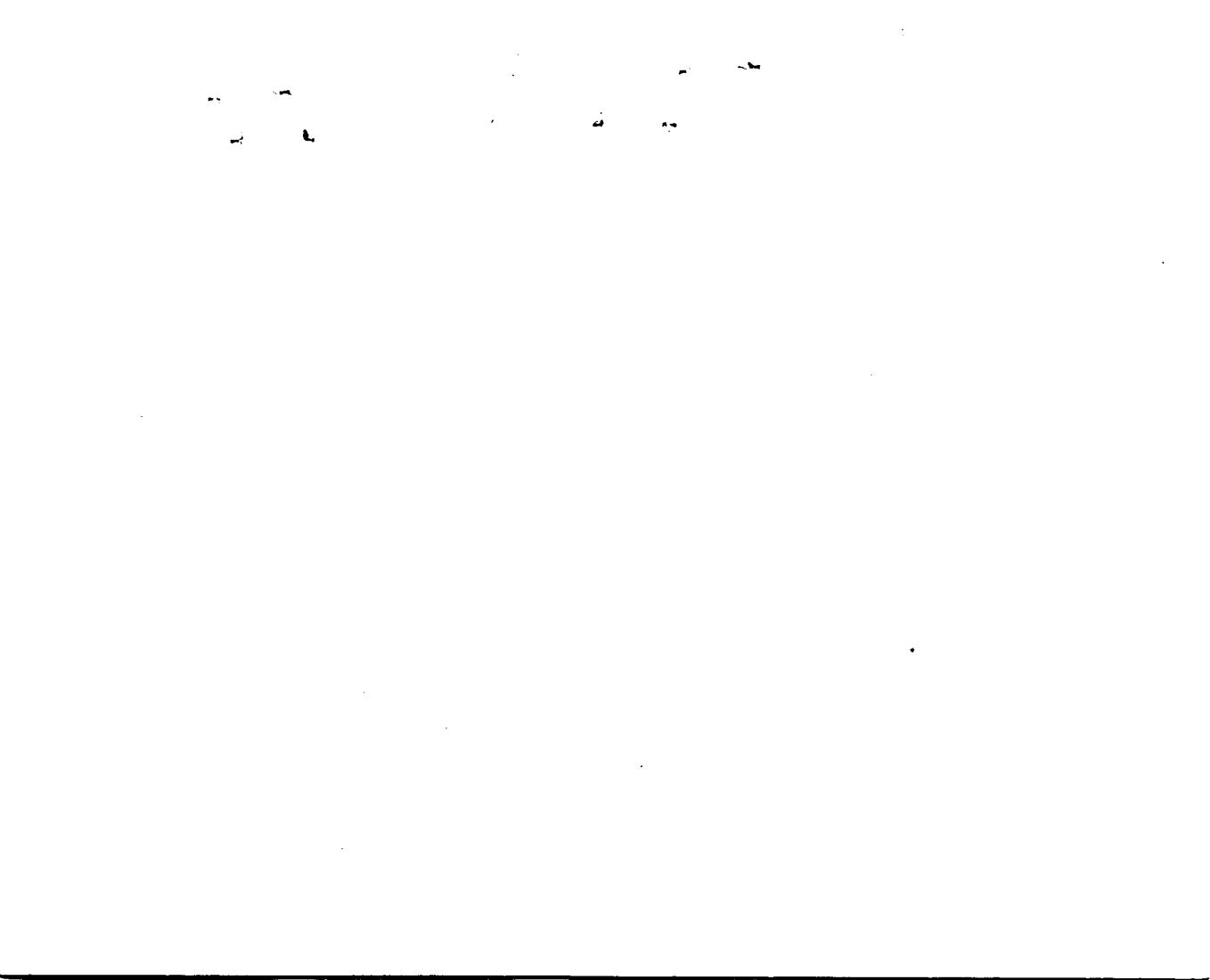
(Signature) E. H. Teed

(Physician or midwife)

Address Coeur d'Alene IdaFiled Mar 27 1929 H. J. Sturges

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 9 1929

PLACE OF DEATH

County of Forest

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 1051

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65019

Local Registrar's No. 36

2. FULL NAME

Infant Lerdy

(a) Residence. No. 1507 Fourth St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 11, 1929

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

10 NAME OF FATHER

Jesse

Lerdy

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Isabel

Kroger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho

14 Informant Jesse Lerdy

(Address) Coeur d'Alene Ida.

15 Filed 2/13/29 E. D. Brennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb
(Month)

11
(Day)

1929
(Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-11-1929 to 2-11-1929

that I last saw him Still born 2-11-1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Still birth

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) E. H. Reed, M. D.

2-12-1929 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest cemetery Date of Burial Feb 13, 1929

20. Undertaker R. B. Mooney Address Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Latimer</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Park Ida</u>		BUREAU OF VITAL STATISTICS	
No. <u>666-229 079-243</u>		CERTIFICATE OF BIRTH	
(If born in hospital or institution give name.)		Registration District No. <u>64</u>	State File No. <u>169668</u>
FULL NAME OF CHILD <u>Stillbirth</u>		Prim. Registration District No. <u>2144</u>	Local Registrar's No. <u>Wood</u>
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>
Date of birth <u>March 29</u> 19 <u>29</u>		(Month) (Day) (Year)	
What prophylactic was used to prevent Ophthalmia Neonatorum?			
Number of child of this mother, including present birth <u>20</u> (a) Born alive and now living <u>one</u>			
Born alive but now dead <u>one</u> Stillborn <u>one</u>			
FATHER FULL NAME <u>Harlow Wood</u>		MOTHER FULL MAIDEN NAME <u>Dorothy Bullock</u>	
Residence (Usual place of abode) <u>Latimer Park Ida</u>		Residence (Usual place of abode) <u>Park Ida</u>	
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>White</u> Age at last Birthday <u>23</u> (Years)		Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)	
Birthplace <u>Idaho</u> (City and State or Country)		Birthplace <u>Idaho</u> (City and State or Country)	
Occupation <u>Laborer</u>		Occupation <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Latimer on the date above stated.

(Signature) Dr. R. P. Meyer

(Physician or midwife)

Address Tray Idaho

Filed March 31 1929

Registrar Lucy M. Pickard

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

107

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Idaho
City of Salmon

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 296-220-030-236 St.Registration District No. 41 State File No. 169678(If born in hospital or institution
give name.)Prim. Registration District No. 2116 Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? y Date of birth June 20 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living ✓Born alive but now dead one Stillborn oneFATHER
FULL NAME Frank BrownMOTHER
FULL MAIDEN NAME Estella ScrogginsResidence (Usual place of abode) SalmonResidence (Usual place of abode) Salmon

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 42 (Years)Color or race White Age at last Birthday 33 (Years)Birthplace Canada (City and State or Country)Birthplace Idaho (City and State or Country)Occupation RancherOccupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 a M.
on the date above stated. 6 months, premature (Signature) F. S. Wright-Led

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address SalmonFiled 3/10 1929 Chris Bellamy

Registrar

RECORDED
INDEXED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2001 BY 60322 UCBAW

100

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Full Name of Child

Where there was no attend at birth, or within the first hour, a statement should make this known. A statement is one that neither parent or shown other evidence of life after birth.

I hereby certify that I attended the birth of this child who was

(Signature)

Address

File

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Lewis
City of Craigmont

No. _____ St. _____

819-203 031-125

(If born in hospital or institution
give name.)

APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

50

169687

Registration District No. 2129 State File No. 13

Prim. Registration District No. _____ Local Registrar's No. _____

Still born

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet -- } and { or other? -- } Number (To be answered only in event of plural births)	in order of birth --	Legitimate? <u>Yes</u>	Date of Birth <u>Mar 3, 1929</u>
				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Arthur Relland Hart
Residence (Usual place of abode) Craigmont RFD
If nonresident, give place and State _____
Color or race white Age at last Birthday 33
Birthplace Boulder Co Colo
(City and State or Country)
Occupation Grain Dealer

MOTHER
FULL MAIDEN NAME Jettie Florence Abels
Residence (Usual place of abode) Craigmont RFD
If nonresident, give place and State _____
Color or race white Age at last Birthday 32
Birthplace Columbia Co Wash
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 2.30 A.
on the date above stated. _____ at _____ M.

(Signature) P. E. Dunsen

(Physician or midwife)
Craigmont Idaho

Address _____

Filed 3-11-29 19 _____

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

APR 25 1997

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 2 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65378

PLACE OF DEATH

County of Lewis
City of Craigmont

CERTIFICATE OF DEATH
Registration District No. 50
Primary Registration District No. 2129

Local Registrar's No. 6

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Still born(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX fen 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

stillborn6 DATE OF BIRTH (month, day and year) Mar 3, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Craigmont Idaho
(State or country)

10 NAME OF FATHER Arthur Holland Hart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Boulder Co Colo

12 MAIDEN NAME OF MOTHER Jettie Florence Abels

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Columbia Co Wash

14 Informant A.R. Hart
(Address) Craigmont Idaho

15 Filed 3/3, 19 29 R. D. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 3, 1929 19
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1929 1929 to Mar 3, 1929 1929
never or ---
that I last saw h --- alive on --- 19---

and that death occurred, on the date stated above, at --- m.

The CAUSE OF DEATH* was as follows:

Stillborn- Cause unknown-
Probably beendead 10 days intra-
uterine (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of ---Was there an autopsy? noWhat test confirmed diagnosis? ---

(Signed) R. D. Smith M. D.
3-3-29 1929 (Address) Craigmont Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
I O O F Cemetery Craigmont 3-4-29 1929

20. Undertaker Clyde Clovis Address Craigmont Ida

APR 16 1997

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.—If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbollic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 5 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Monmouth

City of Rupert

No. 415-211034866 St.

Registration District No. 19

State File No. 169749

Hospital

Primary Registration District No. 2015 Local Registrar's No. 48

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

girl

Twin
Triplet
or other?

} and {

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

3

11

1929

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Blyssol

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

John Walker Davis

FULL
MAIDEN
NAME

MOTHER

Rosa Howell

RESIDENCE

Rupert

RESIDENCE

Rupert

COLOR

white

AGE AT LAST
BIRTHDAY

35

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

31

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Albion, Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at Albion on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Rupert, Idaho

Filed

4-5 1929

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

844-103-034-813
PLACED IN FILE
RECEIVED APR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
169751

County of Minidoka

City of Rupert

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 19 State File No. _____

Hospital Rupert General Primary Registration District No. 2015 Local Registrar's No. 50

FULL NAME OF CHILD unnamed

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>March 31</u> 192 <u>9</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Roy M. Humphries
RESIDENCE Rupert, Idaho
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE So. Carolina
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Ellah Naomi Catwell
RESIDENCE Rupert, Idaho
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho Falls, Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Leah Engle, MD

(Physician or midwife)

Address Rupert, Idaho

Filed 4-3 1929 Ed E. Moore

Registrar.

Registrar.

207

100

1. I attended the birth of this child, who was

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

10-10-68

NAME	FULL	FATHER	MOTHER
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[illegible][illegible]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 12 1929

STATE OF IDAHO

County of Mrs. Perce

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of Lewiston

No. 395 709 35 459 St.

CERTIFICATE OF BIRTH

St. Joseph

(If born in hospital or institution
give name)

Registration District No. 96 State File No. 169920

Prim. Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 9 1929</u> (Month) (Day) (Year)
-----------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 2

FATHER
FULL NAME William F. Tiesmeyer
Residence (Usual place of abode) Orpio, Idaho
If nonresident, give place and State _____
Color or race W. Age at last Birthday 35
(Years)
Birthplace Indiana
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Bertha Mesklings
Residence (Usual place of abode) Orpio, Idaho
If nonresident, give place and State _____
Color or race W. Age at last Birthday 26
(Years)
Birthplace Minnesota
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 5 A. M.
on the date above stated.

(Signature) [Signature]

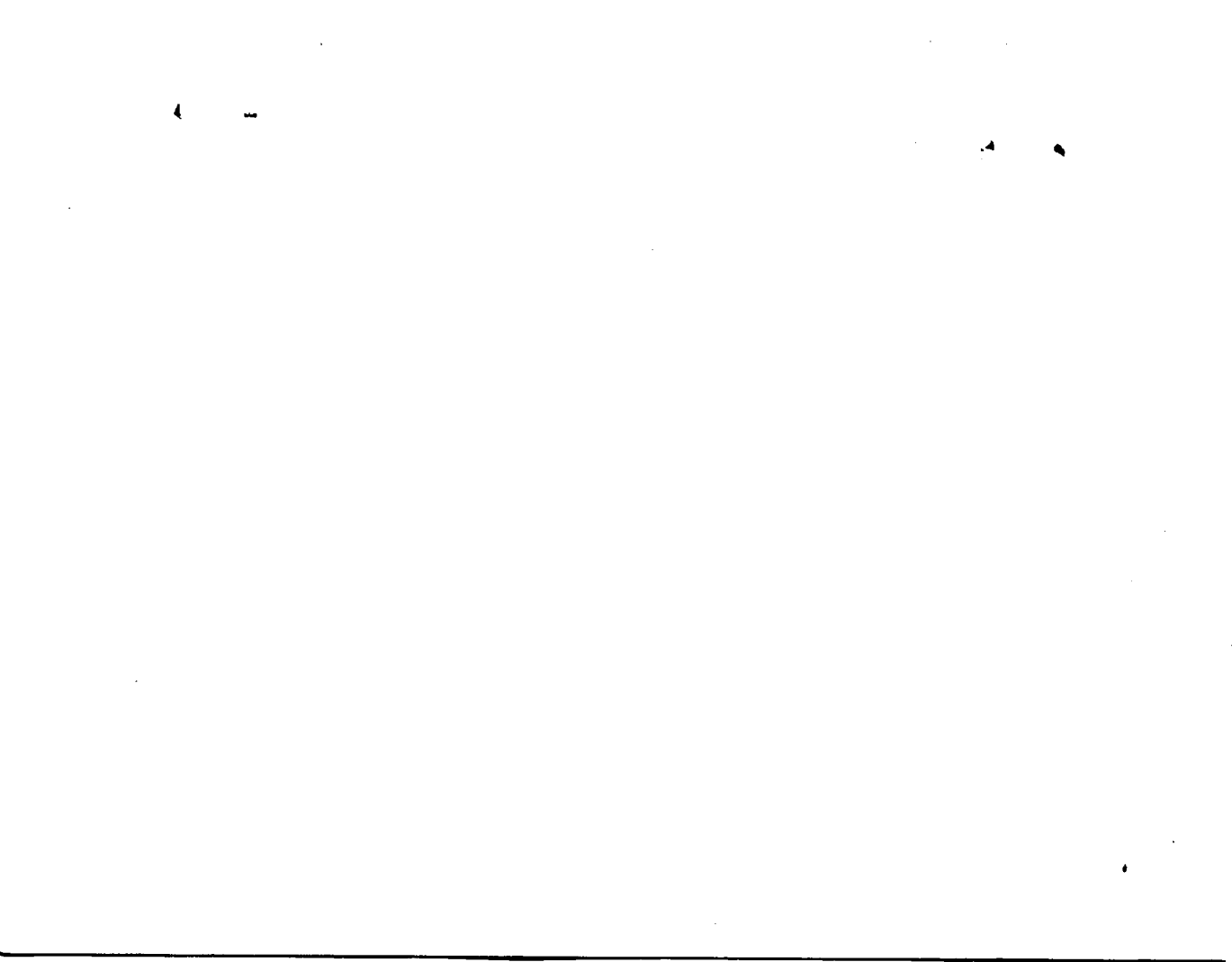
(Physician or midwife)

Address Lewiston, Idaho

Filed Feb 8 1929 Susan E. Bruce

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65541

PLACE OF DEATH
County of Myer
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Siemeyer Baby (Stillborn)

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Stillborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 8th 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Ida
(State or country)

10. NAME OF FATHER W. F. Siemeyer

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER Bertha Siemeyer

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Mrs. R. Hanney
(Address)

15. Filed Feb 9 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 8th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? Enlarged liver

(Signed) _____ M. D.

1-12, 1929 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida Date of Burial _____ 19____

20. Undertaker Vassars and Co Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 12 1929

STATE OF IDAHO

County of New Perve
City of Elveston, Ida

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 317-12th St.

Registration District No. 96 State File No. 169953

465-217 035-165

(If born in hospital or institution
give name.)

Prim. Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD (Stillbirth) Montague

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Feb 17</u> (Month) (Day) (Year) <u>1929</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4th (a) Born alive and now living 3

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>J. M. Montague</u>	MOTHER FULL MAIDEN NAME <u>Nettie Jones</u>
---	--

Residence (Usual place of abode) 317-12th St

If non-resident, give place and State Elveston, Ida

Color or race White Age at last Birthday 4-2 (Years)

Birthplace Ida. (City and State or Country)

Occupation Laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 11:45 A. M.
on the date above stated.

(Signature) Paul Johnson

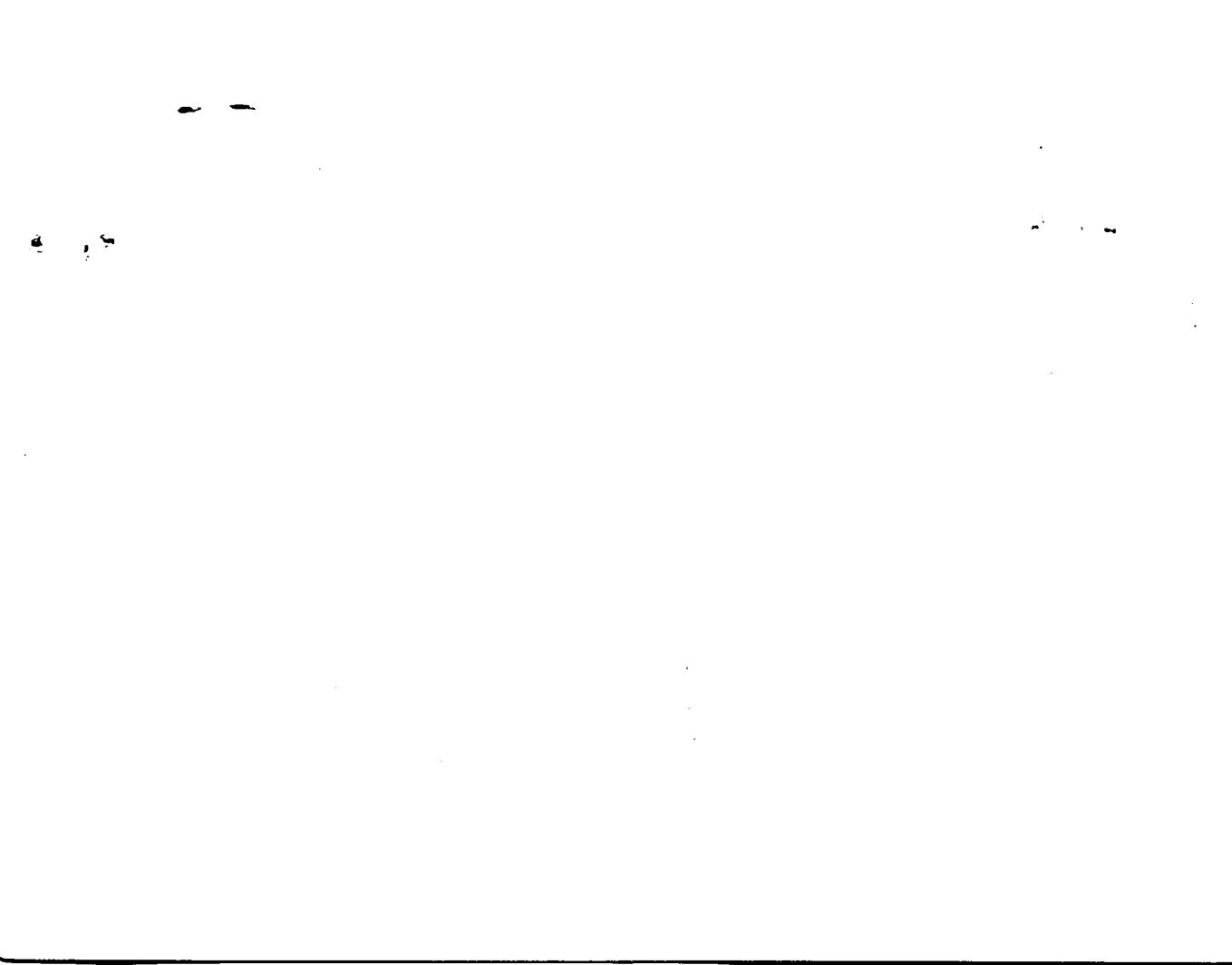
(Physician or ~~midwife~~)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed Mar 8 1929 Susan E. Bruce

Registrar.



RECEIVED APR 19 1929

PLACE OF DEATH

County of Nez Perce.City of Lewiston.STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. St Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Montague.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. 4. COLOR OR RACE White.. 5. Single, Married, Widowed, or Divorced (write the word) Single.5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 2/17/29.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.10. NAME OF FATHER J. M. Montague.11. BIRTHPLACE OF FATHER (city or town) Stanton,
(State or Country) Kentucky.12. MAIDEN NAME OF MOTHER Nettie Gladys Jones.13. BIRTHPLACE OF MOTHER (city or town) Tenn.
(State or Country)14. Informant J. M. Montague
(Address) Lewiston, Idaho.

15. Filed _____, 19____

Registrar

DO NOT WRITE IN THIS SPACE

65567

State File No.

Local Registrar's No.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 17th, 1929.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 17, 1929that I last saw him alive on still born, 19____

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

mother had a cute nephritis from exposure during death of baby died about 2 or 3 days prior to birthCONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul W. Johnson, M. D.
2/18/29., 19____ (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 2/18/29. 19____20. Undertaker Brower-Wann Company. Address Lewiston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

294-121035-813

PLACE OF BIRTH

County of Nez Perce

City of Leidstone

No. St. Joseph Hosp St.

(If born in hospital or institution give name.)

FULL NAME OF CHILD

RECEIVED APR 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

169963

Registration District No. 96 State File No.

Prim. Registration District No. 1009 Local Registrar's No.

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Feb. 21</u> (Month) (Day)	<u>1929</u> (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? X

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Elmer J. Biddison

Residence (Usual place of abode) Clanton Wn

If nonresident, give place and State _____

Color or race Wh Age at last Birthday 41
(Years)

Birthplace Ida
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Ida Halgerson

Residence (Usual place of abode) Clanton Wn

If nonresident, give place and State _____

Color or race Wh Age at last Birthday 35
(Years)

Birthplace Ida
(City and State or Country)

Occupation W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8 P. M.
on the date above stated.

(Signature) [Signature]

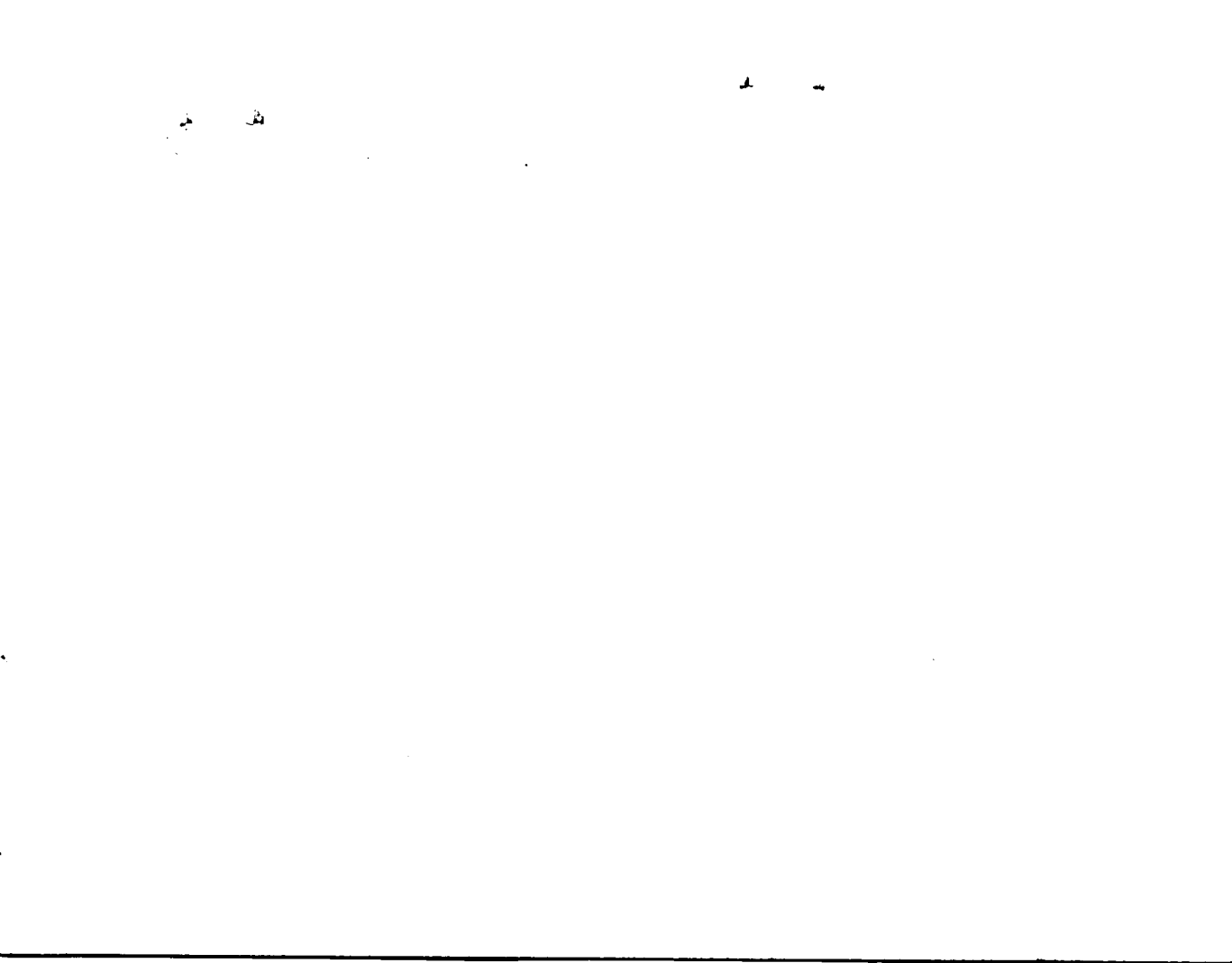
(Physician or midwife)

Address Clanton Idaho

Filed Mar 10 1929 Susan E Bruce

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1929

PLACE OF DEATH

County of Nezperce IdaCity of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

65569

State File No.

Local Registrar's No.

2. FULL NAME De Vere Elmer Biddison

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Stillborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 21, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)10. NAME OF FATHER Elmer F Biddison11. BIRTHPLACE OF FATHER (city or town) Troy, Ida.
(State or Country)12. MAIDEN NAME OF MOTHER Ida Halverson13. BIRTHPLACE OF MOTHER (city or town) Moscow, Ida.
(State or Country)

14. Informant Elmer F Biddison
(Address) Clarkston Wash

15. Filed, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 21, 1929, to Feb. 21, 1929that I last saw him alive on February 21, 1929

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Dehydration, Anoxia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Respiratory Distress
(duration) yrs. mos. ds.18. Where was disease contracted, if not at place of death? Site of place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) W. H. Merchant M. D.1929, 1929 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Clarkston Wash 2/23/29 19

20. Undertaker Address

H. R. Merchant Clarkston, Wn

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 16 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

269 103 035 855
County of *Nez Perce*

City of

CERTIFICATE OF BIRTH

No. St. Registration District No. *128* State File No. *S 169974*

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD *Baby Switzler*

(Certificate of no value without full name of child)

Sex of Child *M* Twin Triplet or other? *and* Number in order of birth *Legitimate?* *yes* Date of birth *Feb 3 1929*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth Number of child of this mother now living, including present birth

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL NAME	RESIDENCE
<i>C. W. Switzler</i>	<i>Sweetwater Idaho</i>	<i>Lidia Henry</i>	<i>Sweetwater Idaho</i>
COLOR <i>Indian</i> AGE AT LAST BIRTHDAY <i>4 1/4</i> (Years)	BIRTHPLACE <i>Oregon</i>	COLOR <i>Indian</i> AGE AT LAST BIRTHDAY <i>1/2</i> (Years)	BIRTHPLACE <i>Idaho</i>
OCCUPATION <i>Farmer</i>		OCCUPATION <i>Housewife</i>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *No Dr. in charge of Case, Susan E. Bruce*
(Physician or midwife)

Address

Filed *Feb 1929* *George Guzman* Registrar

Registrar.

4-11-11

4-11-11

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAR 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **65410**

PLACE OF DEATH

County of *New Paltz*
City of *Sweetwater*

Registration District No. *128*

Primary Registration District No. _____

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Switzler*

(a) Residence. No. _____ St. _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *Indian* 5. Single, Married, Widowed, or Divorced (write the word) *Still Born*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) *Feb 3-1929*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) *Idaho*
(State or country)

10. NAME OF FATHER *C. W. Switzler*

11. BIRTHPLACE OF FATHER (city or town) *Oregon*
(State or Country)

12. MAIDEN NAME OF MOTHER *Lida Henry*

13. BIRTHPLACE OF MOTHER (city or town) *Idaho*
(State or Country)

14. Informant *C. W. Switzler*
(Address) *Sweetwater*

15. Filed *Feb*, 1929 *George Ferguson M.D.*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 3* 19 *29*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

No Dr in charge of Case

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *Simon E. Bruce Registrar* M. D.

_____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Sweetwater* Date of Burial 19____

20. Undertaker *Father* Address *Sweetwater*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day-laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

212-230,036-195
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Lincoln APR 3 1929
City of Malad
No. R.F.B. 1 St. Registration District No. 26 State File No. 169991
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 39

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? yes Date of birth March 30 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 23

FATHER
FULL NAME Everett Baker
RESIDENCE Malad
COLOR white AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Malad
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Mary Ann
RESIDENCE Malad
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Pocatello
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

239 101 041813

PLACE OF BIRTH

RECEIVED APR 5 1929

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 12-C—Rev. 1-1-18

County of TetonCity of Victor

No. _____ St. _____

Hospital _____

Registration District No. 77Primary Registration District No. 2176File No. 170073Registered No. 19FULL NAME OF CHILD they just gave it the name of George Stratton

Sex of Child <u>Boy</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>3</u> <u>1</u> 191 <u>7</u> (Month) (Day) (Year)
FATHER			MOTHER		
FULL NAME <u>George Stratton</u>			FULL MAIDEN NAME <u>Mildred Hatch</u>		
RESIDENCE <u>Victor Idaho</u>			RESIDENCE <u>Victor Idaho</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)		COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)	
BIRTHPLACE <u>Sagan Utah</u>			BIRTHPLACE <u>Victor Idaho</u>		
OCCUPATION <u>Common Labor</u>			OCCUPATION <u>House Keeper</u>		

Number of child of this mother, including present birth, 6 Number of children of this mother now living, including present birth, 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ A. M. on the date above stated. (Regulations stillborn)

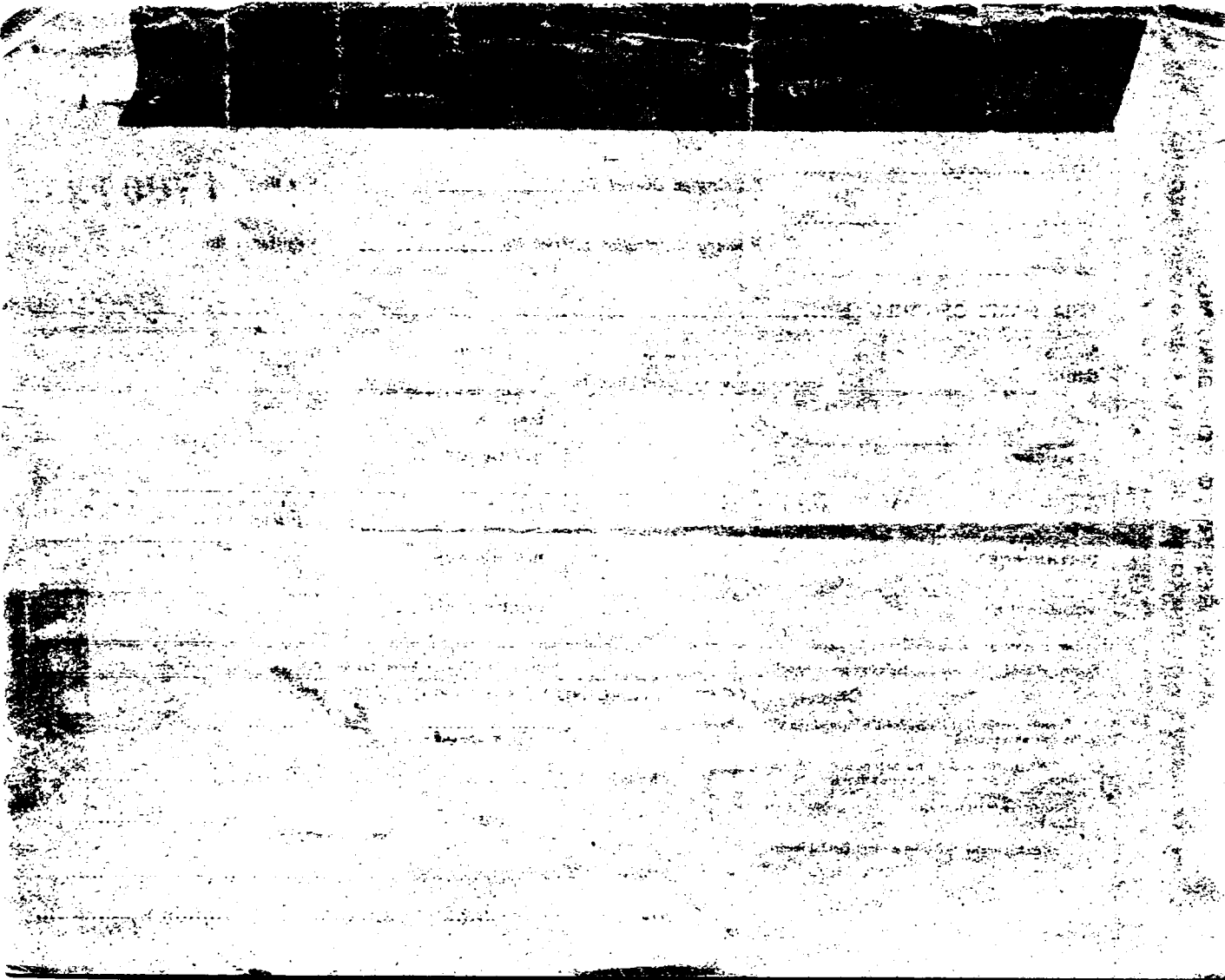
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs. O. B. Curtis

(Signature of midwife)

Given names added from a supplemental report.

Address Victor IdahoFiled 3-30-1929 Martha Marker
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

65606

State File No.

PLACE OF DEATH

County of TetonCity of VictorRegistration District No. 77Primary Registration District No. 3176Local Registrar's No. 9

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Stratten Jr

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) march 1st 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Victor
(State or country) Idaho

10. NAME OF FATHER George Stratten

11. BIRTHPLACE OF FATHER (city or town) Logan
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Mildred Hatch

13. BIRTHPLACE OF MOTHER (city or town) Victor
(State or Country) Idaho

14. Informant Mrs. O. B. Curtis
(Address) Victor, Idaho

15. Filed 3-10- 1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

About 4 month
Primiture

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(Secondary)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Mrs. O. B. Curtis
3-1st- 1929 (Address) Victor, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Victor, Ida. Date of Burial march, 1st 1929

20. Undertaker _____ Address Victor

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 12 1929

STATE OF IDAHO

County of

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of

CERTIFICATE OF BIRTH

No. St.

864 225 042 157

Registration District No. 39 State File No. S 170131

(If born in hospital or institution
give name.)

Prim. Registration District No. 2087 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child female	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? yes	Date of birth 3- 25- 1929 (Month) (Day) (Year)
---------------------	---	-----	--------------------------------	----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FATHER

FULL NAME C. E. Younger

Residence (Usual place of abode) American Fork, Utah

If nonresident, give place and State

Color or race W. Age at last Birthday 39 (Years)

Birthplace Texas (City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Pearl Jeppson

Residence (Usual place of abode) American Fork, Utah

If nonresident, give place and State

Color or race W. Age at last Birthday 24 (Years)

Birthplace Utah (City and State or Country)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:30 A. M.
on the date above stated. { Stillborn }

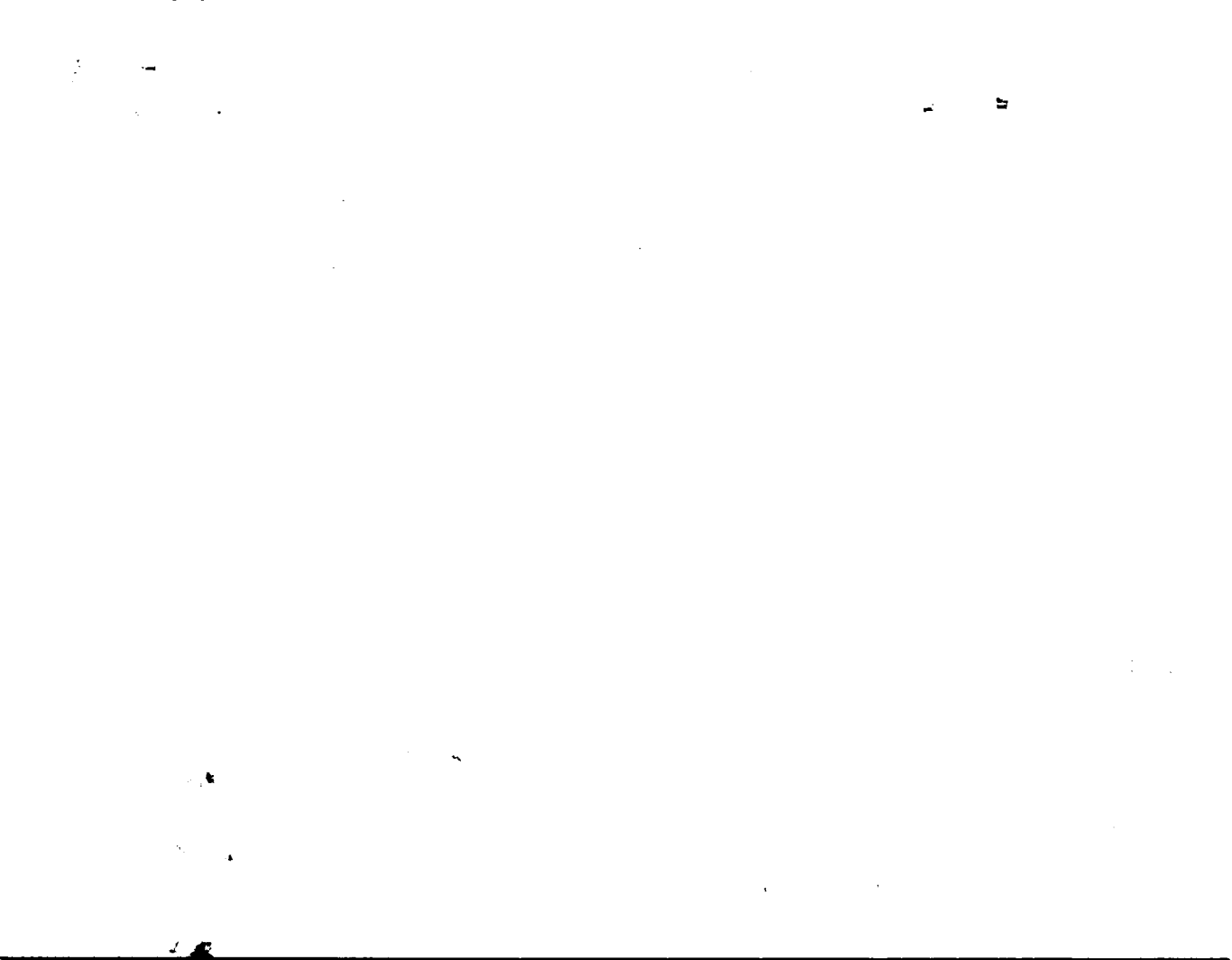
(Signature) E. L. Burman

(Physician or midwife)

Address Buhrle

Filed 3 31 1929 J. H. Murphy Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M. 1-19

RECEIVED APR 12 1929
APR 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

65613

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

7

W

Single

(Write the word.)

6. DATE OF BIRTH

Mar 25

1929

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4-5

1929

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 25

(Month)

(Day)

1929
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 25, 1929, to Mar 25, 1929

that I last saw him alive on Mar 25, 1929

and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature separation of
placenta. Premature birth
6 hrs. or less frequently.
Fetus. (Duration) 10 days.
Contributory factors about 4 or 5 days.
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. L. Barry, M. D.
3-25-29 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

No regular burial

3-25-29

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

APR 22 1929

PLACE OF BIRTH

County of Bannock
City of Idaho Falls
No. 231 St. 109

010-217
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 93 State File No. 170386

Prim. Registration District No. 2112 Local Registrar's No. 110

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin ☐ Triplet ☐ or other? ☐ and ☐ Number in order of birth ☐ Legitimate? Yes Date of birth 3 9 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% Silver Nitrate

Number of child of this mother, including present birth 1 (a) Born alive and now living Yes at birth

Born alive but now dead No Stillborn Yes at birth

FATHER
FULL NAME W. E. Blair

MOTHER
FULL MAIDEN NAME Eva Baxter

Residence (Usual place of abode) Idaho Falls, Ida.

Residence (Usual place of abode) Same

If nonresident, give place and State Apts. City

If nonresident, give place and State Idaho Falls

Color or race W Age at last Birthday 35 (Years)

Color or race W Age at last Birthday 19 (Years)

Birthplace Moran, Ida. (City and State or Country)

Birthplace Salt Lake City (City and State or Country)

Occupation Policeman

Occupation Hammer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:45 a M.
on the date above stated.

(Signature) H. D. Miller

(Physician or midwife)

Address Idaho Falls, Idaho

File March 20 19 29 W. E. Blair

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 170408**

County of Canyon
City of Nampa
No. 523-14 Ave So. St.
253-217 014-243
(If born in hospital or institution give name.)

Registration District No. 7 State File No. 28
Prim. Registration District No. 1000 Local Registrar's No. 28

FULL NAME OF CHILD Joy Aline Becker (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin <u>✓</u> Triplet <u>✓</u> or other? <u>✓</u> (To be answered only in event of plural births)	and { Number in order of birth <u>1</u> }	Legitimate <u>Yes</u>	Date of birth <u>4-17-</u> <u>1929</u> (Month) (Day) (Year)
-----------------------	--	---	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 10%

Number of child of this mother, including present birth 1 (a) Born alive and now living 1
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Augustine Peter Becker
Residence (Usual place of abode) 523-14 Ave So.
If nonresident, give place and State _____
Color or race White Age at last Birthday 34 (Years)
Birthplace Germany (City and State or Country)
Occupation Minister of the Gospel

MOTHER
FULL MAIDEN NAME Fannie Laurene Bucher
Residence (Usual place of abode) 523-14 Ave So.
If nonresident, give place and State _____
Color or race White Age at last Birthday 32 (Years)
Birthplace Astoria Ill. (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

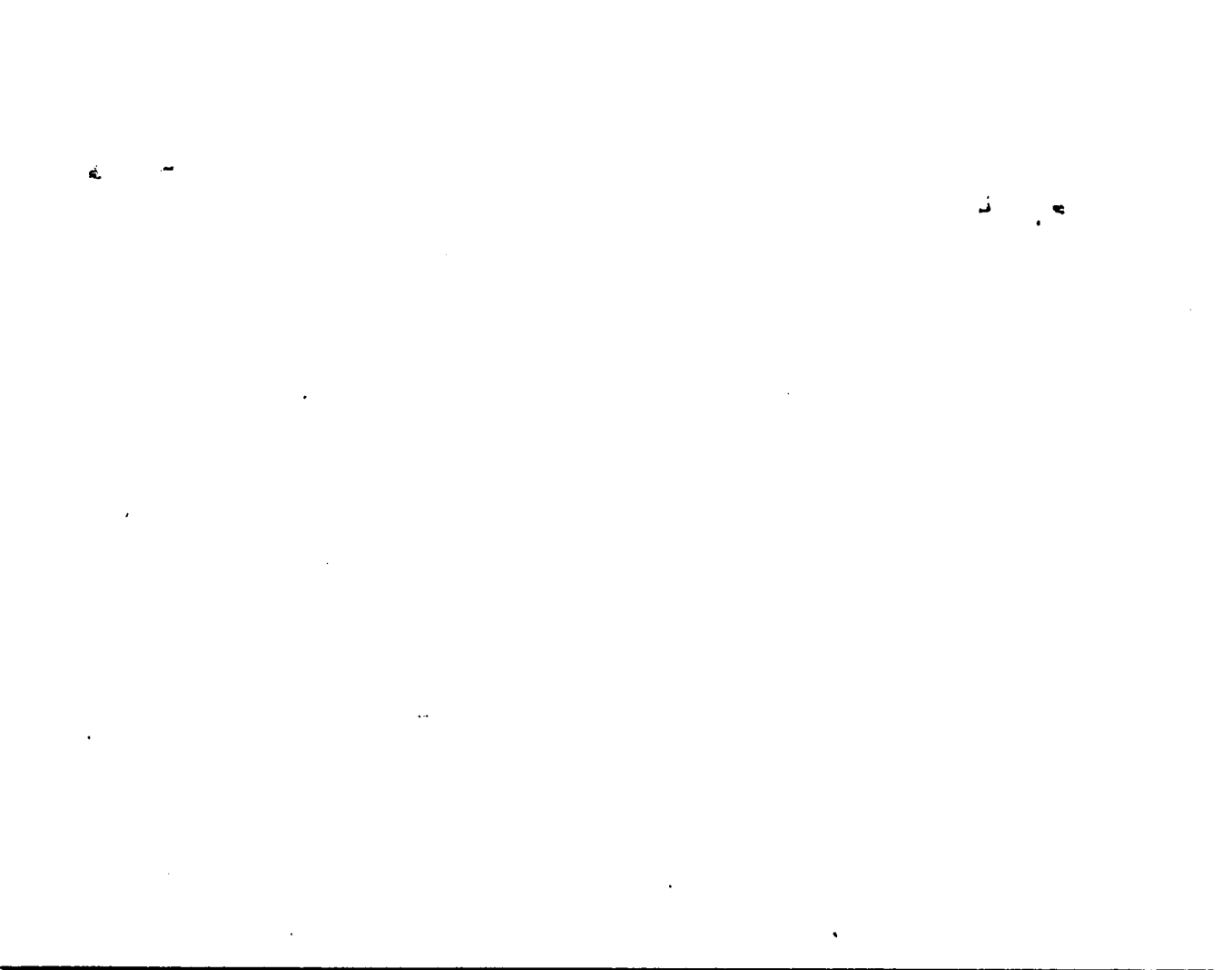
I hereby certify that I attended the birth of this child, who was { Born alive } at 1: P. M. on the date above stated.

(Signature) J. C. Horton
W. D.
(Physician or midwife)

Address Nampa Idaho

Filed 5 19 29 W. D. Smay
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65785

County of Canyon
City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 523-14th Ave. So.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

2. FULL NAME Joy Alene Becker

(a) Residence. No. 523-14th Ave. So. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word)
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) April 17th 1929		
7. AGE Years	Months	Days
If LESS than 1 day, hrs. min.		

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

10. NAME OF FATHER Augustine P. Becker

11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Fannie L. Baker

13. BIRTHPLACE OF MOTHER (city or town) Astoria,
(State or Country) Illinois

14. Informant Rev. A. P. Becker

(Address) 523-14th Ave. So. Nampa

15. Filed 4-17-29 Death away Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-17-29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-17-29, 1929, to 1929, that I last saw h. alive on 4-17-29, 1929, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Stillborn at term

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Horton, M. D.
4-20-29 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Kohlerlawn Nampa 4-18 1929

20. Undertaker Address

Mrs. Nina M. Talley Nampa, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Carroll
City of WadenaNo. 91-21204-693 St.(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 3 State File No. 170419Prim. Registration District No. 2007 Local Registrar's No. 24

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u> </u>	Date of birth <u>Mar 12</u> 19 <u>29</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth 6 (a) Born alive and now living 2Born alive but now dead 3 Stillborn 1FATHER
FULL NAME Charles L BrunerfordResidence (Usual place of abode) WadenaIf nonresident, give place and State Color or race White Age at last Birthday 45 (Years)Birthplace Oak Point, Missouri
(City and State or Country)Occupation FarmerMOTHER
FULL MAIDEN NAME Louisa B NelsonResidence (Usual place of abode) WadenaIf nonresident, give place and State Color or race White Age at last Birthday 38 (Years)Birthplace Farmersville, Georgia
(City and State or Country)Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born } at 2:10 A. M.
on the date above stated. { Stillborn }(Signature) Robert E. Tall

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address WadenaFiled 8/10 1929 Lulu Walden

Registrar

33

2007

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of IDAHOCity of BurleyNo. 366-107016-493 St.(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. 170430

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 7</u> (Month) (Day) (Year) <u>1929</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Iruman Cooper
Residence (Usual place of abode) Burley
If nonresident, give place and State _____
Color or race White Age at last Birthday 35
(Years)
Birthplace Idaho
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Leota William
Residence (Usual place of abode) Burley
If nonresident, give place and State _____
Color or race White Age at last Birthday 28
(Years)
Birthplace Oklahoma
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:15 P.M.
on the date above stated. { Stillborn }

(Signature) Hugh E. Dean
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address BurleyFiled Apr 8 1929 F. H. Cutler

Registrar.

1
109

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 17 1929

STATE OF IDAHO

County of Boise

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Boise

CERTIFICATE OF BIRTH

No. 469-124016-893 St.

Registration District No. 170432 State File No. 170432

(If born in hospital or institution give name.)

Prim. Registration District No. 170432 Local Registrar's No. 170432

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u> { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>Mar 24</u> <u>1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Wilford C. Morgan
Residence (Usual place of abode) Boise
If nonresident, give place and State
Color or race white Age at last Birthday 39 (Years)
Birthplace Iowa
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Bessie M. Hill
Residence (Usual place of abode) Boise
If nonresident, give place and State
Color or race white Age at last Birthday 37 (Years)
Birthplace Washington
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:40 A.M. on the date above stated.

(Signature) W. H. Boney 2d
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Boise 2d

Filed Apr 8 1929 F. H. Cutler

Registrar.

10
D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLAGE OF BIRTH

County of CassiaCity of ElbaNo. 719.117.016-719 St.(If born in hospital or institution
give name.)FULL NAME OF CHILD Lynn J ParishSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 119State File No. 170447Prim. Registration District No. 2198

Local Registrar's No.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
ChildMaleTwin
Triplet
or other?

—

and

{

Number

in order

of birth

—

{

Legiti-

mate?

Yes

Date of

birth

Apr 171929

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ArgyrolNumber of child of this mother, including present birth 5(a) Born alive and now living 4Born alive but now dead NoneStillborn 1FULL
NAMEIsaac B Parish

FATHER

FULL
MAIDEN
NAMEEthel Parish

MOTHER

Residence (Usual place of abode)

Elba Idaho

Residence (Usual place of abode)

Elba Idaho

If nonresident, give place and State

If nonresident, give place and State

Color or race

White

Age at last Birthday

32

Color or race

White

Age at last Birthday

30

Birthplace

Elba Idaho

(City and State or Country)

Birthplace

Elba Idaho

(City and State or Country)

Occupation

Farmer

Occupation

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12:30 A. M.
on the date above stated.

(Signature)

E. J. Salter

(Physician or midwife)

Address

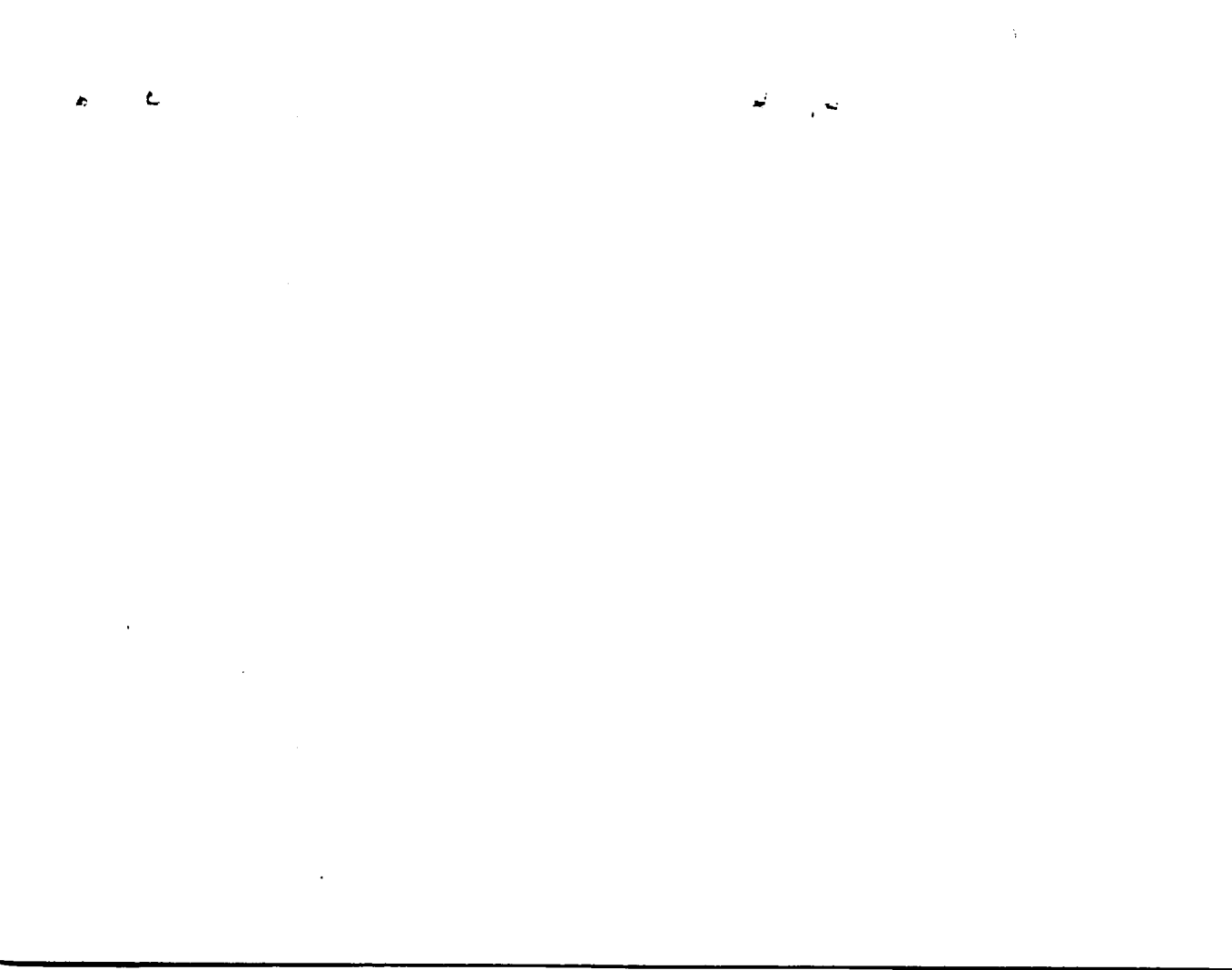
Malta Idaho

Filed

May 41929E. J. Salter

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 65801

1. PLACE OF DEATH RECEIVED MAY 8

Reg. on District No. 19

County of Cassia

Primary Registration District No. 2198

City of Elba

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lynn J. Parish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (write the word.)

6. DATE OF BIRTH.

April 17 1929
(Month) (Day) (Year)

7. AGE

None

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Elba Idaho

10. NAME OF FATHER

Asael B. Parish

11. BIRTHPLACE OF FATHER

(State or Country)

Elba Idaho

12. MAIDEN NAME OF MOTHER

Ethel Rich

13. BIRTHPLACE OF MOTHER

(State or Country)

Elba Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Asael B. Parish

(Address)

Elba Idaho

15.

Filed

May 8 1929 E. J. Salt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

No 1929, to No 1929

that I last saw him alive on No 1929

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH was as follows:

Stillborn
Compressed cord.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

None

(Duration) Yrs. mos. ds.

(Signed)

1/4 1929 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Elba Idaho

DATE OF BURIAL

Apr 17 1929

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of 7City of Preston, Ida

No. St.

553.130.021.625

(If born in hospital or institution give name.)

Registration District No. 27 State File No. SPrim. Registration District No. 2119 Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 30</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? ArgyrolNumber of child of this mother, including present birth 3 (a) Born alive and now living 2Born alive but now dead 1 Stillborn

FATHER FULL NAME <u>Carl E. Nelson</u>	MOTHER FULL MAIDEN NAME <u>Vera Oberly</u>
---	---

Residence (Usual place of abode) Winston, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 27 (Years)Birthplace Hyrum, Utah (City and State or Country)Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

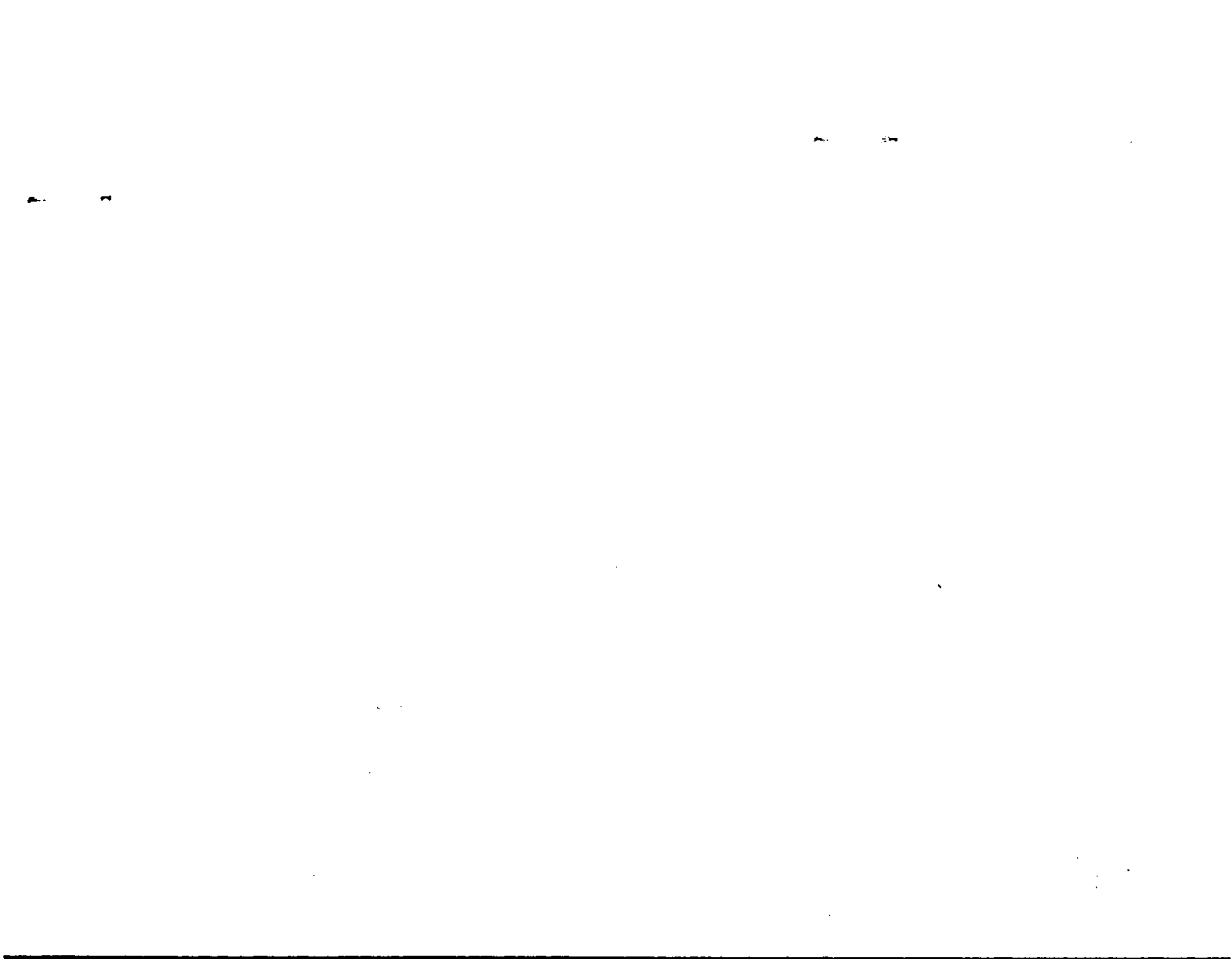
I hereby certify that I attended the birth of this child, who was born alive stillborn at 3:30 P. M. on the date above stated.(Signature) G. R. Oeller

(Physician or midwife)

Address Preston, IdahoFiled May 4 1929 G. R. Oeller

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED MAY 8 1929
PLACE OF DEATH
Franklin
COUNTY OF Franklin
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65837

County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Nielsen
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male	4. COLOR OR RACE white	5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) Apr 30 1929		
7. AGE Years Months Days	If LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED baby (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed, (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Preston Idaho
(State or country)

10. NAME OF FATHER Carl G. Nielsen

11. BIRTHPLACE OF FATHER (city or town) Hyrum Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Very Obery

13. BIRTHPLACE OF MOTHER (city or town) Paradise Utah
(State or Country)

14. Informant Carl G. Nielsen
(Address) Weston Idaho

15. Filed May 2 1929
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 30 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at . m.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hydrocephalus
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Quiley, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Weston Idaho
Date of Burial
May 2 1929

20. Undertaker
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 4 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jerome

City of Jerome

No. 142-102027231 St. 3

(If born in hospital or institution
give name.)

CERTIFICATE OF BIRTH

Registration District No. 18 State File No. 170570

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <u> </u> Triplet <u> </u> or other <u> </u> (To be answered only in event of plural births)	Number <u>4</u> in order <u> </u> of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 2 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn

FATHER
FULL NAME Alvin Ambrose

Residence (Usual place of abode) Fairfield Idaho

If nonresident, give place and State

Color or race white Age at last Birthday 37 (Years)

Birthplace Arkansas
(City and State or Country)

Occupation Section Foreman

MOTHER
FULL MAIDEN NAME Pauline Blackman

Residence (Usual place of abode) Fairfield Idaho

If nonresident, give place and State

Color or race white Age at last Birthday 27 (Years)

Birthplace England
(City and State or Country)

Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was at 12 P. M.
on the date above stated.

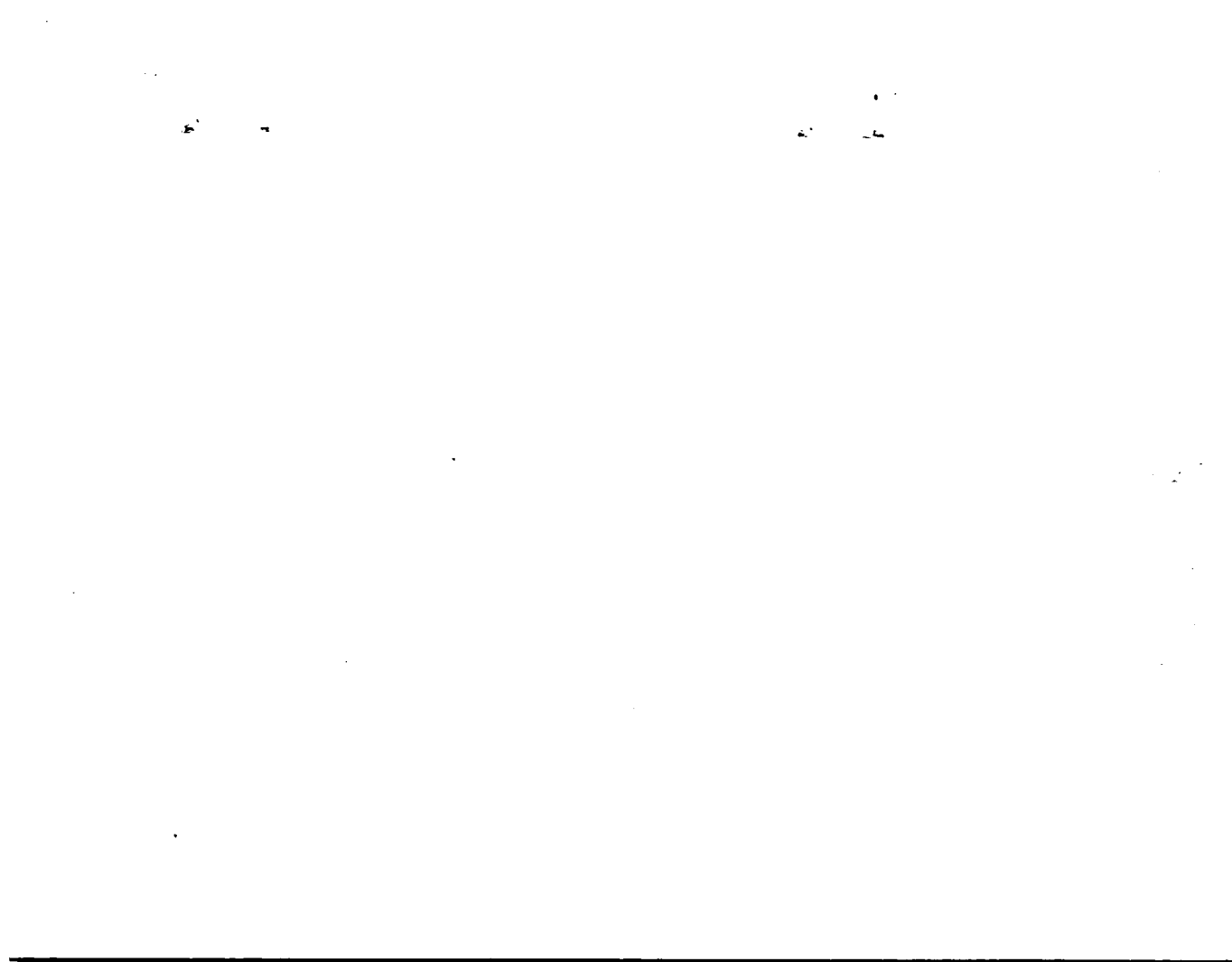
(Signature) Chas F Zeller m.d.

(Physician or midwife)

Address Jerome Idaho

Filed 3/21 1929 Chas F Zeller
Inc Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of JeromePrimary Registration District No. -City of Jerome

(No. _____, _____ St.)

File No. 65875

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Ambrose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhiteInfant
(Write the word.)

6. DATE OF BIRTH

March
(Month)2
(Day)1929
(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
-
- (b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Jerome Idaho.

10. NAME OF FATHER

Alvin Ambrose.

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas.

12. MAIDEN NAME OF MOTHER

Pauline Blackman

13. BIRTHPLACE OF MOTHER

(State or Country)

England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pauline Blackman.(Address) Fairfield Idaho.

15.

Filed 3/2 1929 Chas F Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March
(Month)2
(Day)1929
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/21929.

to

3/21929.

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Transverse Position Probable Cord
Premature rupture membranes
with Arm presentation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. Zeller M. D.4/20 1929 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____ 191____

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

170570+

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 4 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

170574

County of Jerome

City of Jerome

No. 464-1227-154 St.

(If born in hospital or institution give name.)

Registration District No. 18 State File No. 170574

Prim. Registration District No. 18 Local Registrar's No. 170574

FULL NAME OF CHILD Joseph Ruben Dodge

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins <u>1</u> and <u>1</u> in order of birth <u>1</u> and <u>2</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>April 11</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead None Stillborn None

FATHER	MOTHER
FULL NAME <u>Melvin Dodge</u>	FULL MAIDEN NAME <u>Gertrude Anderson</u>
Residence (Usual place of abode) <u>Jerome</u>	Residence (Usual place of abode) <u>Jerome</u>
If nonresident, give place and State <u>None</u>	If nonresident, give place and State <u>None</u>
Color or race <u>White</u> Age at last Birthday <u>23</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>20</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Labr.</u>	Occupation <u>House wif.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:50 P. M. on the date above stated.

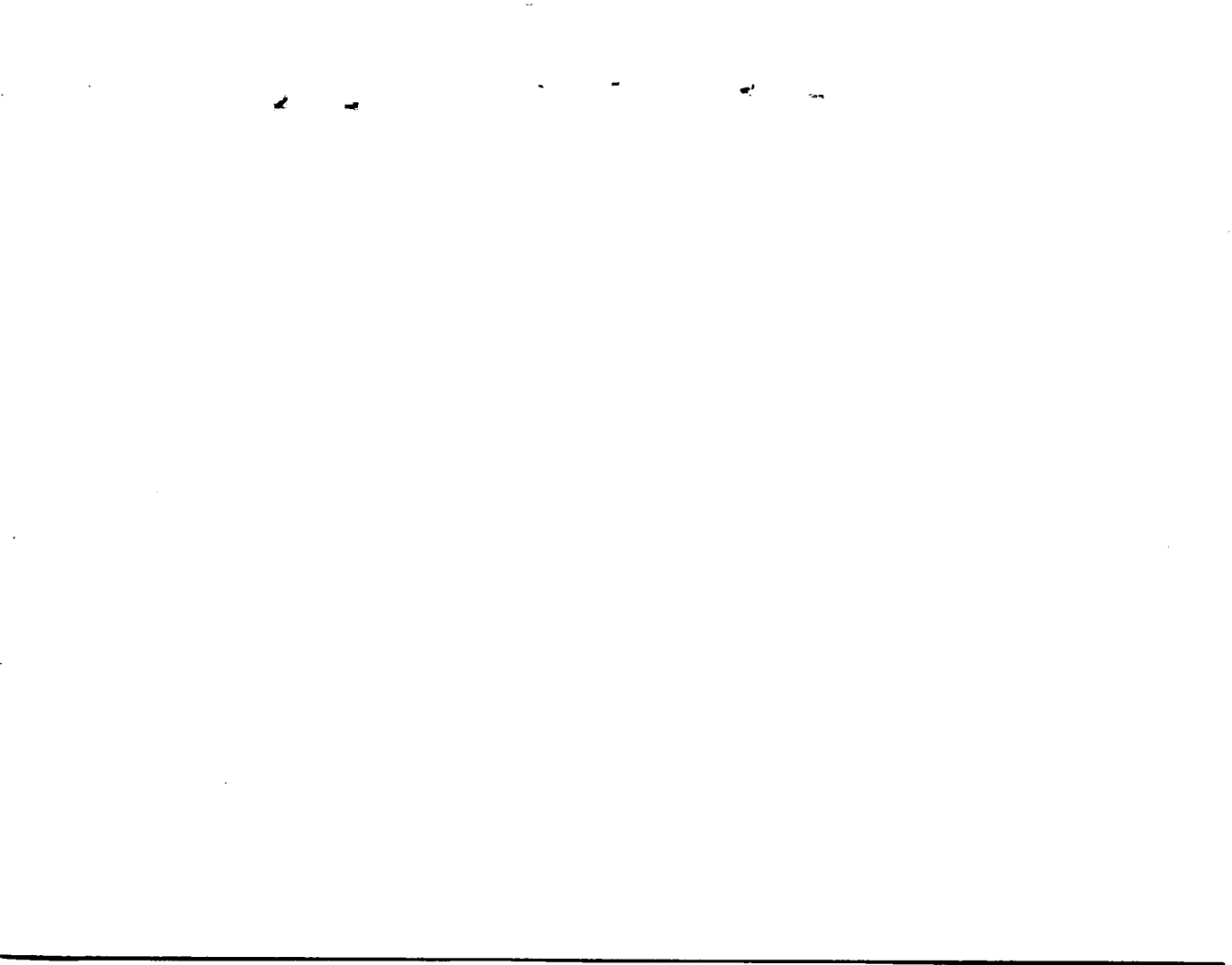
(Signature) Chas F Zeller M.D.

(Physician or midwife)

Address Jerome Idaho

Filed 5/12 1929 Chas F Zeller Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED MAY 4 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No. _____

City of Jerome

(No. _____, _____ St.)

File No. 65872

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Lodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male white Infant (write the word.)

6. DATE OF BIRTH

April 11 1
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Jerome Idaho

10. NAME OF
FATHER

Melvin Lodge

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Gertrud Anderson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melvin Lodge

(Address) Jerome Idaho

15.

Filed 4/12 1929 Chas F Zeller
Inc Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature undeveloped Infant
Twin

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. Zeller M. D.

4/12 1929 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

613-124-027-386

PLACE OF BIRTH

RECEIVED MAY 4 1929

County of Jerome

City of Jerome

No. _____ St. _____

(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 18 State File No. 170576

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Male

Twin
Triplet other } and { Number
or other } of birth
(To be answered only in event of plural births)

3

Legiti-
mate?

yes

Date of
birth

April 24

1929

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____

Stillborn 1

FATHER
FULL
NAME

John L Walker

Residence (Usual place of abode)

Jerome

If nonresident, give place and State _____

Color or race

white

Age at last Birthday

31
(Years)

Birthplace

Idaho

(City and State or Country)

Occupation

Farmer

MOTHER
FULL
MAIDEN
NAME

Amy Thompson

Residence (Usual place of abode)

Jerome

If nonresident, give place and State _____

Color or race

white

Age at last Birthday

28
(Years)

Birthplace

Idaho

(City and State or Country)

Occupation

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn } at 6 - A. M.
on the date above stated.

(Signature) Chas F Zeller M.D.

(Physician or midwife)

Address

Jerome Idaho

Filed

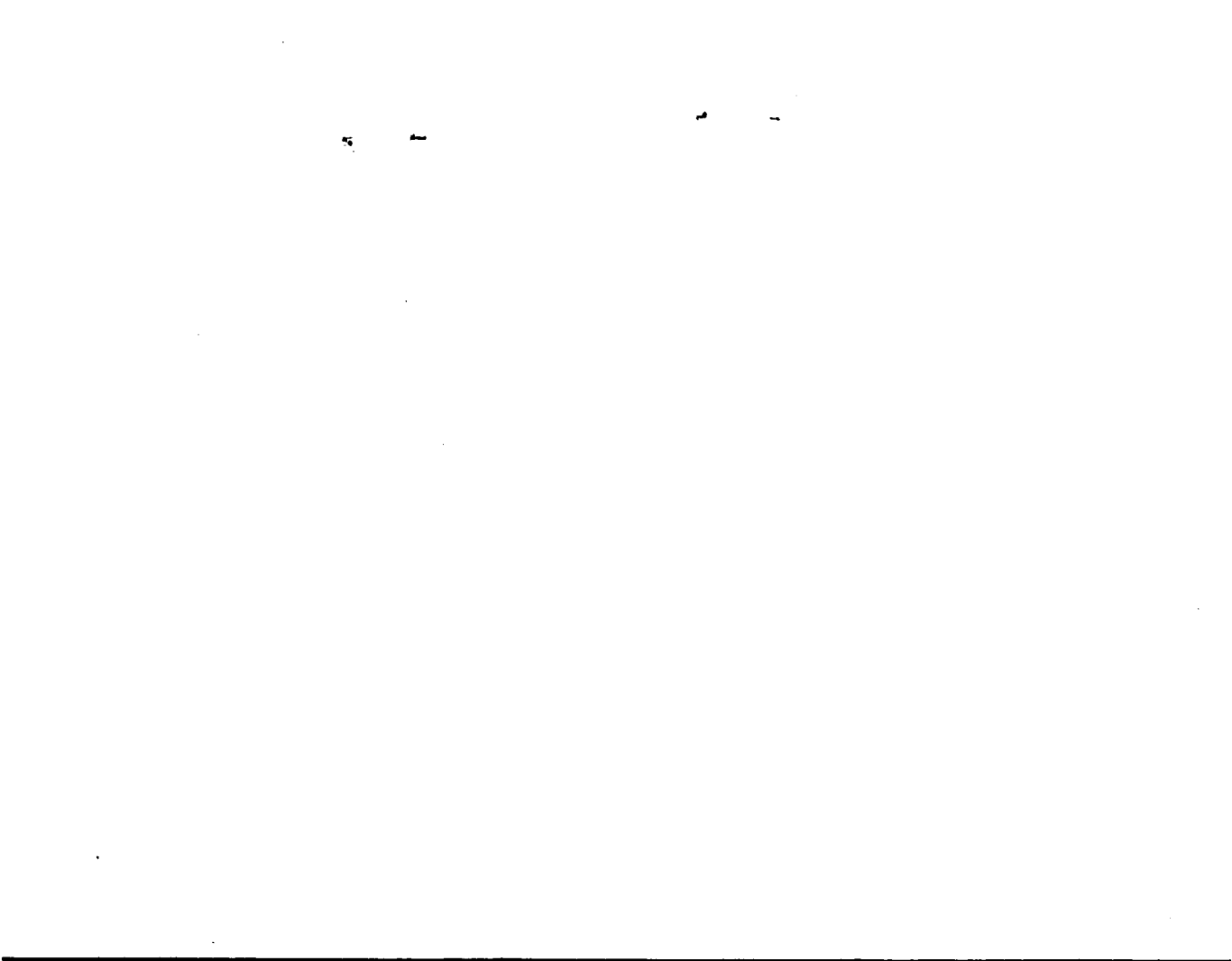
4/24

1929

Chas F Zeller

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 MAY 4 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 18
County of Jerome Primary Registration District No. _____
City of Jerome (No. _____, St.) _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Baby Walker

File No. 65874
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) _____

6. DATE OF BIRTH April 24 1929
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Jerome Idaho

10. NAME OF FATHER John L Walker

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Amy Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L Walker
(Address) Jerome Idaho

15. Filed April 24 1929 Chas F Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____, to 191____, that I last saw h_____ alive on 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Still Born Infant

Degeneration Placenta
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. Zeller M. D.
4/26 1929 (Address) Jerome, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

20. UNDERTAKER _____ ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

455-1221035-145
PLACE OF BIRTH
RECEIVED MAY 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Pay

City of Lewiston

CERTIFICATE OF BIRTH 170756

No. St. Registration District No. 96 State File No.

Hospital White Primary Registration District No. 1229 Local Registrar's No.

FULL NAME OF CHILD Clarence John Denham

(Certificate of no value without full name of child)

Sex of Child male } and { Number in order of birth 1 Legitimate? yes Date of birth 4 27 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 30% Argrol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Marcus A. Denham
RESIDENCE Clarksburg Wash
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Cottonwood Idaho
OCCUPATION Care (manager)

MOTHER
FULL MAIDEN NAME Sophia Jungert
RESIDENCE Clarksburg Wash
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Cottonwood
OCCUPATION Nurse R.N.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. J. White

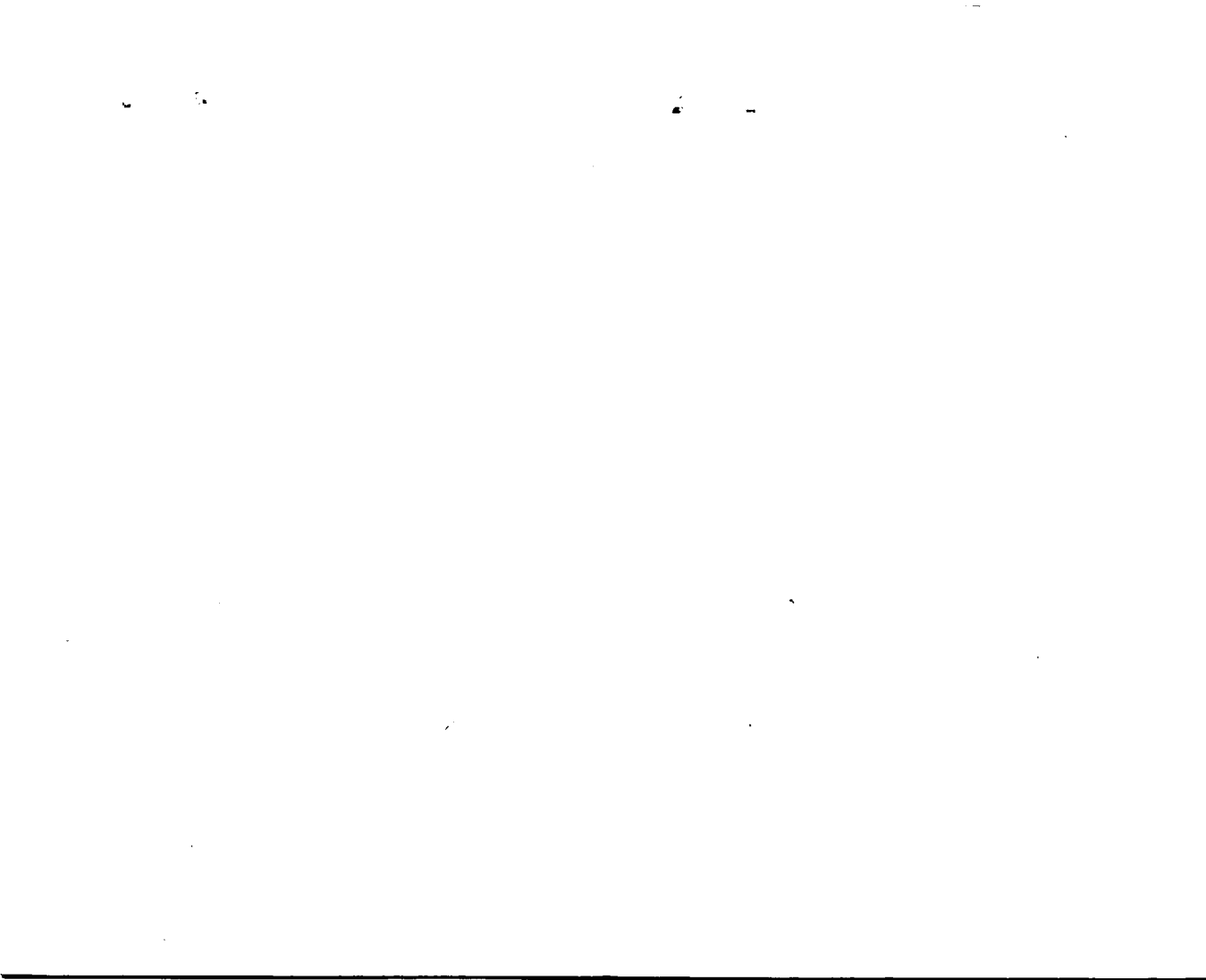
(Physician or midwife)

Address Lew-Ida

Filed May 8 1929 Dwan E. Bruce

Registrar.

Registrar.



MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 65949

PLACE OF DEATH

County of Nezperce, Ida
City of Lewiston, Ida.

CERTIFICATE OF DEATH

Registration District No. 95
Primary Registration District No. 1009

Local Registrar's No. _____

(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Clarence Denham

(a) Residence. No. _____ St. _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Stillborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)

10. NAME OF FATHER

Marion A Denham

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Cottonwood, Ida.

12. MAIDEN NAME OF MOTHER

Sophia Jungert

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Cottonwood, Ida.

14. Informant Marion A Denham

(Address) Clarkston, Wash.

15. Filed Apr May 10 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 27- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on still born, 19____

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY Unknown Cause
(Secondary) file with mother 3 months before
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) E. L. White, M. D.

4-29 1929 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Clarkston, Wn 4/29/29 19

20. Undertaker Address

H.R. Merchant Clarkston Wn

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

295-218-038-249
PLACE OF BIRTH
County of PAYETTE
City of _____
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Registration District No. 4 State File No. 170774
Prim. Registration District No. 1008 Local Registrar's No. 20

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Two	} and {	Number in order of birth	Two	Legiti- mate?	Date of birth	Feb. 18, 1929
	Triplet or other?						

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silvol

Number of child of this mother, including present birth 7 (a) Born alive and now living 4
Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Clarence L. Kinney

MOTHER
FULL MAIDEN NAME Laura Burgess

Residence (Usual place of abode) Payette, County

Residence (Usual place of abode) Payette County

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 43
(Years)

Color or race White Age at last Birthday 32
(Years)

Birthplace Colorado.
(City and State or Country)

Birthplace Idaho.
(City and State or Country)

Occupation Farmer

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE* Stillborn
Born alive }
Stillborn } 7.30 A. M.

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Signature) J. C. Woodward
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho
Filed Mar. 20 19 29
Registrar. J. C. Woodward

FEB 9 1944

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

65581

State File No.

RECEIVED MAR 22 1929

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 8

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Kinner

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE H 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 18

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Full born

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

10. NAME OF FATHER Clarence Kinner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Laura Burgess

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Clarence Kinner (Address) Route Payette Ida

15. Filed Feb 19 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 18, 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1929 to Feb. 18 1929 that I last saw her alive on -----, 1929 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows: Stillborn twin-second birth Dystocia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted If not at place of death?

Did an operation precede death? No Date of -----

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) _____, M. D. Feb. 19 1929 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ontario Ore Date of Burial Feb 19 1929

20. Undertaker D. H. Adams Address Johnson Farm Co Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

319-211-040-385
PLACE OF BIRTH APR 23 1929

County of Shoshone
City of Burke Ida.

No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S170799

Registration District No. 2a State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 1011 Local Registrar's No. 51

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>3-11-1929</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Joseph Paul Carlisle</u>	FULL MAIDEN NAME <u>Belda Percie Lynch</u>
---	--

Residence (Usual place of abode) Burke Ida Residence (Usual place of abode) Burke Ida

If nonresident, give place and State

Color or race White Age at last Birthday 29 Color or race White Age at last Birthday 18
(Years) (Years)

Birthplace Wilkeson Wash Birthplace Spokane Wash
(City and State or Country) (City and State or Country)

Occupation None Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

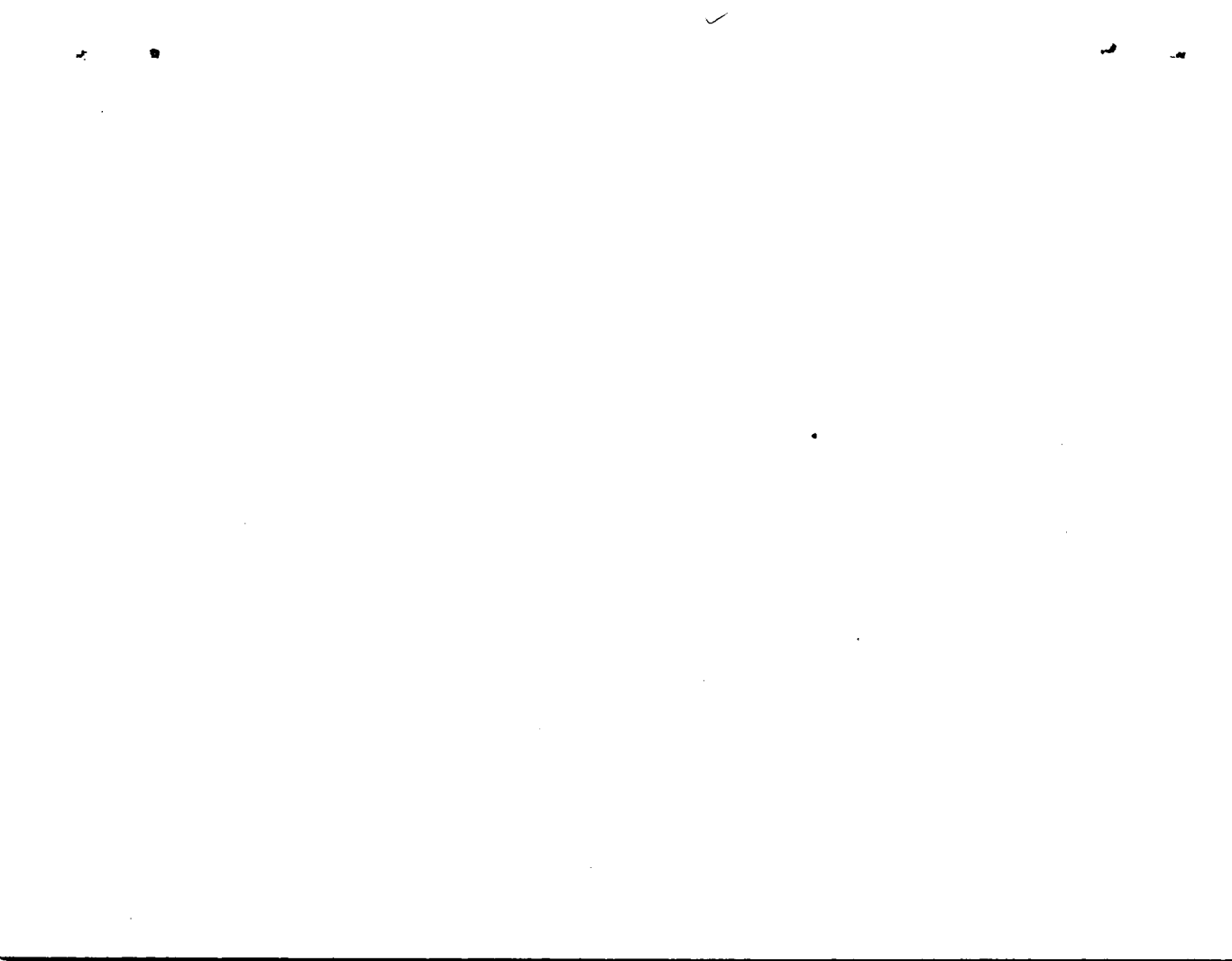
I hereby certify that I attended the birth of this child, who was Stillborn at 6:30 P. M.
on the date above stated.

(Signature) Dr. M. W. E. Mowery
Physician
(Physician or midwife)

Address Wallace Ida

Filed Nov 30 1929 J. L. Lingley
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

65975

State File No.

Local Registrar's No. 23

PLACE OF DEATH

County of ShoshoneCity of BurkeRegistration District No. 7Primary Registration District No. 1011(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Yellow dog St. Burke

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

StillbornIf LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Burke Idaho

10 NAME OF FATHER

Joe Corli11 BIRTHPLACE OF FATHER (city or town)
(State or country)Wilkinson, Wash.

12 MAIDEN NAME OF MOTHER

Vilda Lynch13 BIRTHPLACE OF MOTHER (city or town)
(State or country)SpoKane, Wash.

14

Informant

(Address)

Mr. Joseph Corli
Burke, Idaho

15

Filed

1, 1929W. E. Sawyer

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

MAY 11 1929

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

____, 19____, to ____ 19____

that I last saw her alive on ____and that death occurred, on the date stated above, at 69%

The CAUSE OF DEATH was as follows:

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? NO Date of ____Was there an autopsy? NOWhat test confirmed diagnosis? NO(Signed) W. E. Sawyer, M. D.____, 1929 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wallace IdahoMarch 12 1929

20. Undertaker

J. A. Bever

Address

Ward Undertaking Co.Wallace Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

219-105-64-141
PLACE OF BIRTH
RECEIVED MAY 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Idaho
City of Driggs
No. _____ St. _____ Registration District No. 77 State File No. 170822
Hospital _____ Primary Registration District No. 9176 Local Registrar's No. 36

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? + Date of birth 3/5 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER J. A. Kortchner
RESIDENCE Driggs, Ida.
COLOR W. AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Ut.
OCCUPATION School Teacher

FULL MAIDEN NAME MOTHER Harriet Adams
RESIDENCE Id.
COLOR Do. AGE AT LAST BIRTHDAY 24
(Years)
BIRTHPLACE Ut.
OCCUPATION H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 6.30 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192____

(Signature) H. T. Tedner, M.D.

(Physician or midwife)

Address Driggs, Ida.

Filed 5-6-1929 Martha Marker

Registrar.

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DECLARATION OF BIRTH

Investigator _____
 Primary Investigation District No. _____
 Registration Number No. _____
 State File No. _____

UNITED STATES OF AMERICA

14-00000

[illegible]

What polychlorinated biphenyls were used in 1970?

Number of children this mother, including present birth

Handwritten text at the bottom of the page, likely a signature or date, is mostly illegible due to blurring and bleed-through. It appears to contain the words "Handwritten" and "1961".

ЗАДАЧА

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JUN 73

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ENCLOSURE

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NOTARIZADO

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was William

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(911384912)

(Physician or physician)

4407 bba

9149

75021951

18718799R

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 10 1929

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 77

County of

Primary Registration District No. 2176

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 65983
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

3/6 1929

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

389-126082 RECEIVED
PLACE OF BIRTH 469

MAY 13 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Buhl

No. _____ St.

CERTIFICATE OF BIRTH

Registration District No. 39 State File No. 170876

Prim. Registration District No. 2087 Local Registrar's No. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4-26</u> (Month) (Day) (Year) <u>1929</u>
-----------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 13 (a) Born alive and now living 11

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME W. H. Chrisman

MOTHER
FULL MAIDEN NAME Ma Morris

Residence (Usual place of abode) Buhl

Residence (Usual place of abode) Buhl

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race W. Age at last Birthday 37
(Years)

Color or race W. Age at last Birthday 37
(Years)

Birthplace Mo.
(City and State or Country)

Birthplace Mo.
(City and State or Country)

Occupation farmer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 9 a M.
on the date above stated.

(Signature) J. H. Murphy

(Physician or midwife)

Address Buhl Ida

Filed 4-29 1929 J. H. Murphy

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

STATE OF NEW YORK
DEPARTMENT OF TAXATION
BUREAU OF TAXATION
OFFICE OF THE COMPTROLLER
ALBANY, N. Y.

(If born in America or naturalized)
First Registration District No. 1087 Local Registrars No.
Registration District No. 1087 State File No.

CHILD TO SMAN LIFE

[illegible]

Number of child of the mother including present birth (a) Born alive and now living 11

NAME	MAIDEN NAME	PELL	MOTHER
Residence (Usual place of abode)	Residence (Usual place of abode)	Residence (Usual place of abode)	Residence (Usual place of abode)

Birthplace	Age at last birthday (Years)	Color or race	Age at last birthday (Years)	Birthplace	Age at last birthday (Years)	Color or race	Age at last birthday (Years)
1111	11	1111	11	1111	11	1111	11

[Faint, illegible markings]

CONFIDENTIAL

Signature _____

Address _____
City _____ State _____

(Print name or initials)

When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathed nor
showed outward evidence of life after birth.

It is one that never ceases nor
 should make the man a stillborn
 or midwife, then the father, householder,
 When there was no stirring physician

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **66005**

PLACE OF DEATH
 County of **Winn Falls**
 City of **Buhl**

Registration District No. **39**
 Primary Registration District No. **2087**

Local Registrar's No. _____

(No. _____)
 (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **(Winn) Chisham**

(a) Residence. No. _____ St. _____

(Usual place of abode)
 Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **W.** 4. COLOR OR RACE **W.** 5. Single, Married, Widowed, or Divorced (write the word) **Single**
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of **Winn**
 6. DATE OF BIRTH (month, day and year) **Apr. 26 1929**
 7. AGE Years Months Days **Winn** If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Winn**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (city or town) **Buhl Ida.**
(State or country)10. NAME OF FATHER **W. W. Chisham**11. BIRTHPLACE OF FATHER (city or town) **Idaho**
(State or Country)12. MAIDEN NAME OF MOTHER **Ina Morris**13. BIRTHPLACE OF MOTHER (city or town) **Idaho**
(State or Country)14. Informant **J. H. Murphy**
(Address) **Buhl**15. Filed **4-26**, 19**29** **J. H. Murphy**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 26 1929**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born. Had been dead in utero 20-30 days

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY **No apparent cause**
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? **W.** Date of _____Was there an autopsy? **W.**

What test confirmed diagnosis?

(Signed) **J. H. Murphy**, M. D.**4-26**, 19**29** (Address) **Buhl**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **At home** Date of Burial **4-26 1929**20. Undertaker **Winn** Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

555-1091-001-463
PLACE OF BIRTH

County of Ada
City of Berge
No. 1 Alphamus St.
Hospital

(If born in hospital or institution give name.)

Registration District No. 2 State File No. 171004

Prim. Registration District No. 1004 Local Registrar's No. 153

FULL NAME OF CHILD "Stillborn" Everett

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>August 9th</u> (Month) (Day) (Year) <u>1928</u>
--------------------------	---	-----	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn Yes

FULL NAME <u>Warren Benjamin Everett</u>	FATHER	FULL MAIDEN NAME <u>Sadie Mott Everett</u>	MOTHER
--	--------	--	--------

Residence (Usual place of abode) Yacerville Id

If nonresident, give place and State _____

Color or race White Age at last Birthday 40

Birthplace South Dakota (Years) _____

Occupation Clark (City and State or Country) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 7 P M. on the date above stated.

(Signature) Fred G. Puring Ed

(Physician or midwife)

Address Berge Id

Filed 578 1929 W.H. Rhodes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 12 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62657

PLACE OF DEATH

County of AdaCity of BoiseRegistration District No. 2Primary Registration District No. 1004Local Registrar's No. 210(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Everett(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug. 9, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)10. NAME OF FATHER W. B. Everett11. BIRTHPLACE OF FATHER (city or town) South Dakota
(State or Country)12. MAIDEN NAME OF MOTHER Ladie Motto13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant W. B. Everett
(Address) Idaho City, Idaho15. Filed 8/10, 1928 Paula M. Bonnes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 9 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-9, 1928, to 8/9, 1928
that I last saw him alive on Monday, 1928
and that death occurred, on the date stated above, at 8 PM m.The CAUSE OF DEATH* was as follows: StillbornStrangulation due to the placental cord being wrapped around neck
CONTRIBUTORY fact lay 14 hrs.
(duration) yrs. mos. ds. Child born dead18. Was there a disease or injury which caused death?
If not, the place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred A. Bonnes M. D.8/10, 1928 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Placerville Idaho Date of Burial Aug 10 192820. Undertaker Summers & Theis Address Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 1711039

County of Benewah
City of Paratella
No. 212-2281003-214 St.

Registration District No. 28 State File No. 1711039

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 9212

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate

Date of
birth

Apr. 28 1929
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Wesley Stanford Baker

MOTHER
FULL MAIDEN NAME Rebecca Sampson

Residence (Usual place of abode) Paratella

Residence (Usual place of abode) Paratella

If nonresident, give place and State

If nonresident, give place and State

Color or race Wht Age at last Birthday 39 (Years)

Color or race Wht Age at last Birthday 21 (Years)

Birthplace Gova, Utah (City and State or Country)

Birthplace Dauntiful, Utah (City and State or Country)

Occupation Salesman W. M. Co.

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 6:30 a M. on the date above stated.

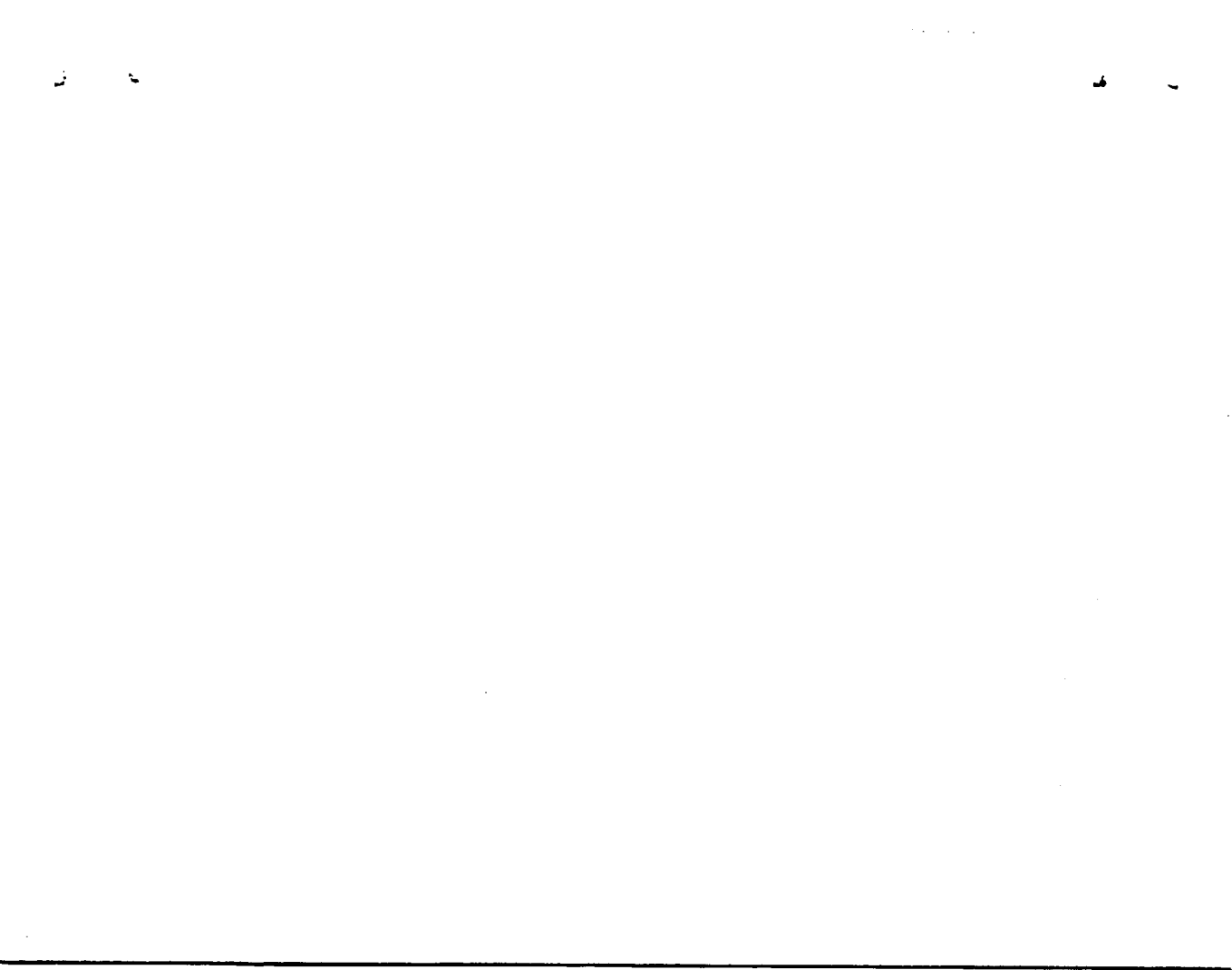
(Signature) D. C. Ray

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Paratella, Idaho

Filed 5/1 1929 W. M. Co. Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 23 1929

PLACE OF DEATH

County of BANNOCK
City of POCATELLO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161

(No. GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66066

Local Registrar's No. 5552

2. FULL NAME INFANT BABCOCK

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 28, 1929

7. AGE Years Months Days if LESS than 1 day,
STILL BORN min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE INFANT

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO, IDA.
(State or country)

10. NAME OF FATHER R. S. BABCOCK

11. BIRTHPLACE OF FATHER (city or town) UTAH
(State or Country)

12. MAIDEN NAME OF MOTHER NEVILLA RAMPTON

13. BIRTHPLACE OF MOTHER (city or town) UTAH
(State or Country)

14. Informant R. S. BABCOCK
(Address) POCATELLO, IDAHO

15. Filed 4/29, 1929 Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Apr 28, 1929

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Congenital hydrocephalus
Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) D. C. Ray, M. D.

4/29, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal MOUNTAIN VIEW Date of Burial April 29, 1929

20. Undertaker ARTHUR W. HALL Address POCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

799-2 31-206-845
PLACE OF BIRTH RECEIVED JUN 8
County of Bingham
City of Blackfoot, Idaho
No. West Alice St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 151 State File No. 171110

Prim. Registration District No. 1007 Local Registrar's No. 164

FULL NAME OF CHILD Shirley Jean

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>May 31</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argysol

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Floyd E. Privett

Residence (Usual place of abode) Blackfoot Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 20
(Years)

Birthplace Oaklahoma
(City and State or Country)

Occupation Labor

MOTHER
FULL MAIDEN NAME Emma Hunter

Residence (Usual place of abode) Blackfoot, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 20
(Years)

Birthplace Utah
(City and State or Country)

Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 7.30 A.M.
on the date above stated.

(Signature) G. W. Mitchell

(Physician or midwife)

Address Blackfoot, Idaho

Filed June 3 1929 Mr. Charles E. Davis
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

shows the evidence of his later birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

66116

State File No.

Local Registrar's No. 107

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Blackfoot Registration District No. 121City of _____ Primary Registration District No. 1007(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Shirley Jean Prineett

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

May 31

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

Construction

(c) Name of employer

Anderson9 BIRTHPLACE (city or town)
(State or country)Blackfoot
Idaho

10 NAME OF FATHER

Wloyd Prineett11 BIRTHPLACE OF FATHER (city or town)
(State or country)Oklahoma

12 MAIDEN NAME OF MOTHER

Emma Hunter13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Utah14 Informant Wloyd Prineett(Address) Blackfoot Idaho15 Filed May 31, 1929 McWaters E. L. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May
(Month)31
(Day)1929
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 31, 1929, to May 31, 1929,that I last saw her on May 31, 1929,and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Primaries - 7 months

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? ✓Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) F. W. White M. D.5/31, 1929 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wells Mac-Add May 31 1929

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

717-105-006-386
PLACE RECEIVED

County of Bingham
City of Blackfoot, Ida
No. _____ St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
171133

Mrs. Frances Hospital
(If born in hospital or institution give name.)

Registration District No. 121 State File No. _____
Prim. Registration District No. 1007 Local Registrar's No. 136

FULL NAME OF CHILD James Chas. Paxton

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	<u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth	<u>May 5,</u>	<u>1929</u>
		(To be answered only in event of plural births)			<u>yes</u>	(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Nothing

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Lester L. Paxton
Residence (Usual place of abode) Blackfoot
If nonresident, give place and State _____
Color or race white Age at last Birthday 27 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Mechanic

MOTHER
FULL MAIDEN NAME Emma Marie Lyon
Residence (Usual place of abode) Blackfoot,
If nonresident, give place and State _____
Color or race white Age at last Birthday 22 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:05 AM.
on the date above stated.

(Signature)

J. C. Hampton M.D.
(Physician or midwife)

Address

Filed

Blackfoot 2 days -
June 1 1929
M. C. Carter E. J. J.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. 1944

1940-1941 District No. 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 8

FULL NAME OF CHILD: [REDACTED] DATE OF BIRTH: [REDACTED]

[illegible]

What prophylactic was used to prevent hemorrhoids? Neostigmine

1. The first of these is the fact that the Commission has not yet received any information from the Government of the United States regarding the activities of the Committee for the Liberation of the People of the East (CLPE) in the United States. The Commission is therefore unable to provide any information on this matter.

CONFIDENTIAL

[illegible]

10-10-1964

1947

SECRET

CONFIDENTIAL

on the date above stated.

* Where there was no attending physician

ed, should make this return. A return or midwife, then the father must be

shows other evidence of life after death.

*Where there was no attending physician or midwife then the father, mother, grandparent, or other person who was present at the birth, should make this return. A child is one that neither breast nor milk shows other evidence of life after birth.

PROFESSOR TROSKIN, ALEXANDER (DE ORIGINATZ) HTIVS YLIMADZ ETIMZ?
not about the human body? I think the birds are much more to study in. H. J. J.
He's a little bit more to study in than to teaching and our class

FORM V. S. No. 1-1-19

1. PLACE OF DEATH

County of *Touhy*City of *Chicago*
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *121*Primary Registration District No. *1007*(No. *Francis Hosp, 306 W. Jackson*)*James Charles Paxton*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *65100*Registered No. *92*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

May 5 1929
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

May 6 1929

1929

McWaters & Co.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1929, to May 5 1929
that I last saw her *alive* *still born*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

premature b. & sus placenta previa
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Hamplatt M. D.
5-5-1929 (Address) *Blackfoot, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Basalt Cemetery**May 5 1929*

20. UNDERTAKER

ADDRESS

*Sora France**Blackfoot*

MAY 28 1980

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.* *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MAY 28 1980

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

141-126-014-389
PLACE OF BIRTH **RECEIVED JUN 8 1929** STATE OF IDAHO
County of Canyon DEPARTMENT OF PUBLIC WELFARE
City of Nampa BUREAU OF VITAL STATISTICS
No. Swanlan St. 9 CERTIFICATE OF BIRTH **S 171247**
(If born in hospital or institution give name.) - Registration District No. 9 State File No. 171247
Prim. Registration District No. 2006 Local Registrar's No. 7
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child M Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 1-26 1929
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? neo serum
Number of child of this mother, including present birth un (a) Born alive and now living un
Born alive but now dead un Stillborn un
FATHER FULL NAME Fred Adams FULL MAIDEN NAME Suella Christopherson
Residence (Usual place of abode) Huston Residence (Usual place of abode) Huston
If nonresident, give place and State un If nonresident, give place and State un
Color or race white Age at last Birthday un (Years) Color or race white Age at last Birthday 37 (Years)
Birthplace Kentucky (City and State or Country) Birthplace Idaho (City and State or Country)
Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 A. M.
on the date above stated.

(Signature) Horace P. Belknap
W. J. Padden
(Physician or midwife)

Address Idaho
Filed 1/3 1929 W. J. Padden
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

JAN 8

RECEIVED FEB 8 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64496

County of Canyon

City ofampa

Registration District No.

Primary Registration District No. 1010

Local Registrar's No.

(No. Good Samaritan Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lloyd Gene Adams

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 26-29

7. AGE Years Months Days If LESS than 1 day, hrs. or min. no min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) nampa, Idaho (State or country)

10. NAME OF FATHER Fred Adams

11. BIRTHPLACE OF FATHER (city or town) Kentucky (State or Country)

12. MAIDEN NAME OF MOTHER Luella Christopher

13. BIRTHPLACE OF MOTHER (city or town) Iowa (State or Country)

14. Informant Mr. Fred Adams

(Address) R.F.D. #3 Caldwell, Idaho

15. Filed 30 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26th 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1929, to Jan 26, 1929 that I last saw him alive on Stillborn, 19 and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Still born and had been dead days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous intrauterine (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Blyskal, M. D.

1/26 1929 (Address) nampa.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Kentucky nampa 1-26 1929

20. Undertaker Address

Wm. A. Taylor nampa, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

449-206-014-445
PLACE OF BIRTH

County of Canyon
City of Caldwell
No. 1204 Arthur St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 3 State File No. 171291

(If born in hospital or institution give name.)

Prim. Registration District No. 1005 Local Registrar's No. 99

FULL NAME OF CHILD

(Stillborn) Doris June

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? Yes	Date of birth			
Female					4/26	29	19	
					(Month)	(Day)	(Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME C. H. Murphy
1204 Arthur St. Caldwell
Residence (Usual place of abode)

MOTHER
FULL MAIDEN NAME Alice Dunagan
1204 Arthur St. Caldwell,
Residence (Usual place of abode)

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 28
(Years)

Color or race White Age at last Birthday 26
(Years)

Birthplace Wash.
(City and State or Country)

Birthplace Iowa
(City and State or Country)

Occupation Laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 6 A M.
on the date above stated. Stillborn

(Signature) E. M. Cole

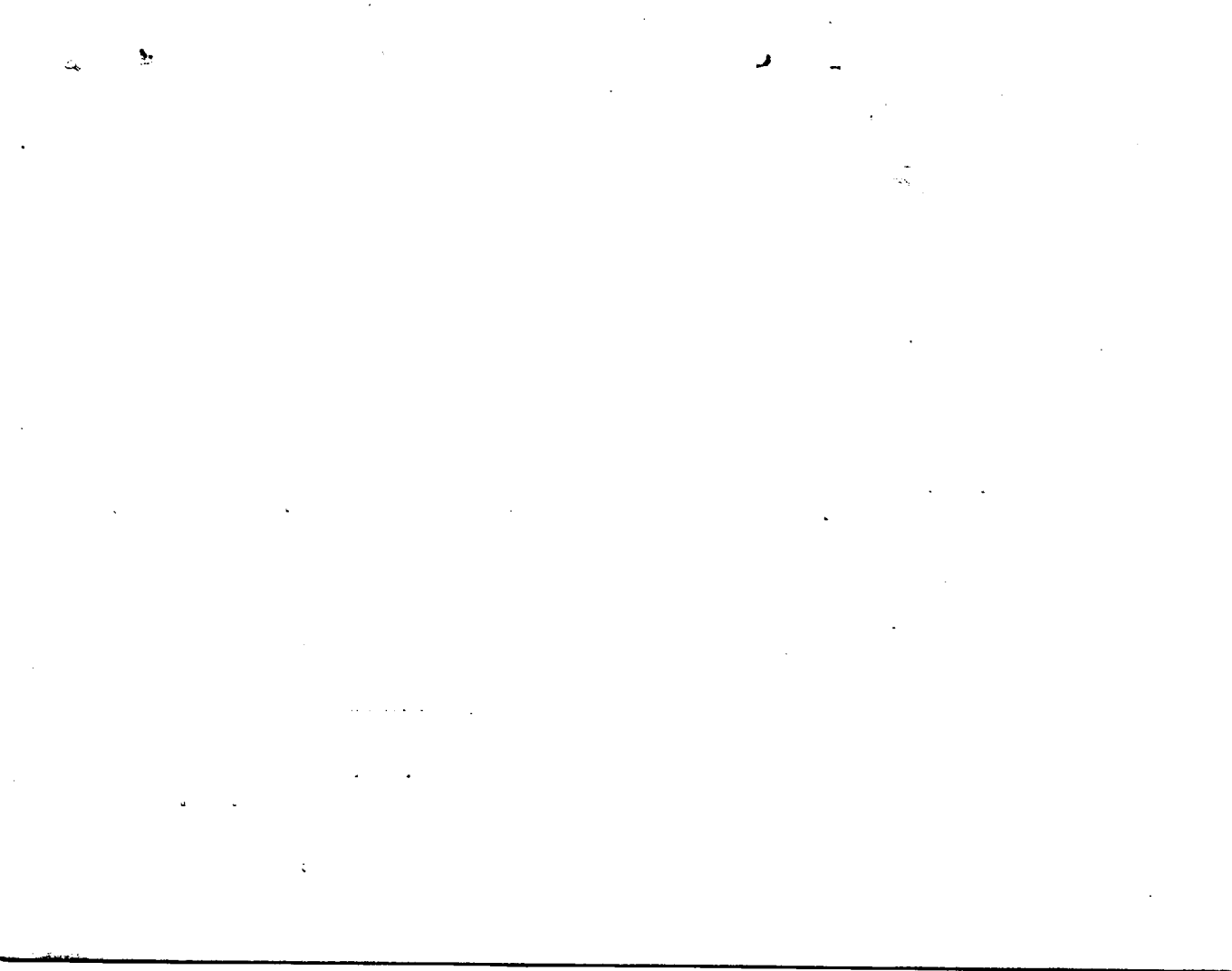
M. D.

(Physician or midwife)

Address Caldwell, Idaho

Filed 4. 26. 1929 John S. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
66178
State File No.

PLACE OF DEATH
County of Canyon
City of Colchester

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 36

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Meris Jane Murphy

(a) Residence. No. 204 Colchester Bldg. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 26 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Birth - - - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Colchester Idaho
(State or country)

10. NAME OF FATHER C.H. Murphy

11. BIRTHPLACE OF FATHER (city or town) Wash.
(State or Country)

12. MAIDEN NAME OF MOTHER Alice Menagan

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Mrs C.H. Murphy
(Address) Colchester Idaho

15. Filed 4-26-, 1929. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1929 to April 26 1929
that I last saw him Still Birth alive on April 26 1929
and that death occurred, on the date stated above, at Colchester Idaho m.

The CAUSE OF DEATH* was as follows:
Per maternal birth

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis Symptoms

(Signed) John S. Meyer, M. D.

4, 1929 (Address) Colchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) WHETHER ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Philoles Ceme. Date of Burial 4-26-1929

20. Undertaker Evan Gatter and Friends Address Colchester Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1929

STATE OF IDAHO

County of Franklin

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Preston, Ida

CERTIFICATE OF BIRTH

S171333

No. 59-103-021-749 St.

Registration District No. 27 State File No. 2119

(If born in hospital or institution
give name.)

Prim. Registration District No. 2119 Local Registrar's No. 2119

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>May 3</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Maralba Kershaw</u>	MOTHER FULL MAIDEN NAME <u>Grace Purnell</u>
---	---

Residence (Usual place of abode) Preston, Ida

If nonresident, give place and State Preston, Ida

Color or race White Age at last Birthday 32 24
(Years) (Years)

Birthplace Preston, Ida Mont.
(City and State or Country) (City and State or Country)

Occupation Farmer Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 11-15 P. M.

(Signature) G. W. Shatto

M. D.
(Physician or midwife)

Address Preston, Ida

Filed June 4 19 29 C. R. C. C. C.

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. B. 1929 RECEIVED JUN 6 1929 CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin
City of Preston, Ida

Registration District No. _____
Primary Registration District No. _____
(No. _____ St.)

State File No. _____
Local Registrar's No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Kershaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

May 3 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employed)

9. BIRTHPLACE

(State or Country) Preston, Ida

10. NAME OF FATHER

Maralba Kershaw

11. BIRTHPLACE OF FATHER

(State or Country) Preston, Ida

12. MAIDEN NAME OF MOTHER

Grace Pinnell

13. BIRTHPLACE OF MOTHER

(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maralba Kershaw
(Address) Preston, Ida

15. Filed 19 Q. R. Pottles
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1929 to May 3 1929,
that I last saw h. alive on May 3 1929,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Death came on before birth.
In second of child birth.

(Duration) yrs. mos. ds.
Contributory (Secondary) Placenta Rupture
(Duration) yrs. mos. ds.
(Signed) G. W. States M. D.
May 4 1929 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Ida

DATE OF BURIAL

May 4 1929

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1929

STATE OF IDAHO

County of Gordium

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Gordium

CERTIFICATE OF BIRTH

No. 2051024-8692

St. Hospit

Registration District No. 24

State File No. S171370

362

(If born in hospital or institution
give name.)

Registration District No. 24

Local Registrar's No. 362

FULL NAME OF CHILD William LeRoy Bushby

(If unborn, substitute the word "Stillbirth" for name of child)

Sex of
Child girl

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
macy yes

Date of
birth 5-5-

(Month)

(Day)

1929
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1

(a) Born alive and now living 0

Born alive but now dead 0

Stillborn 1

FULL
NAME

FATHER

Leslie Bushby

FULL
MAIDEN
NAME

MOTHER

Nellie Wisner

Residence (Usual place of abode) Richfield

Residence (Usual place of abode) Richfield

If nonresident, give place and State Idaho

If nonresident, give place and State Idaho

Color or race white

Age at last Birthday 25

(Years)

Color or race white

Age at last Birthday 20

(Years)

Birthplace Idaho

(City and State or Country)

Birthplace Idaho

(City and State or Country)

Occupation farmer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at 7:30 A M.

(Signature) J. A. Cromwell M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

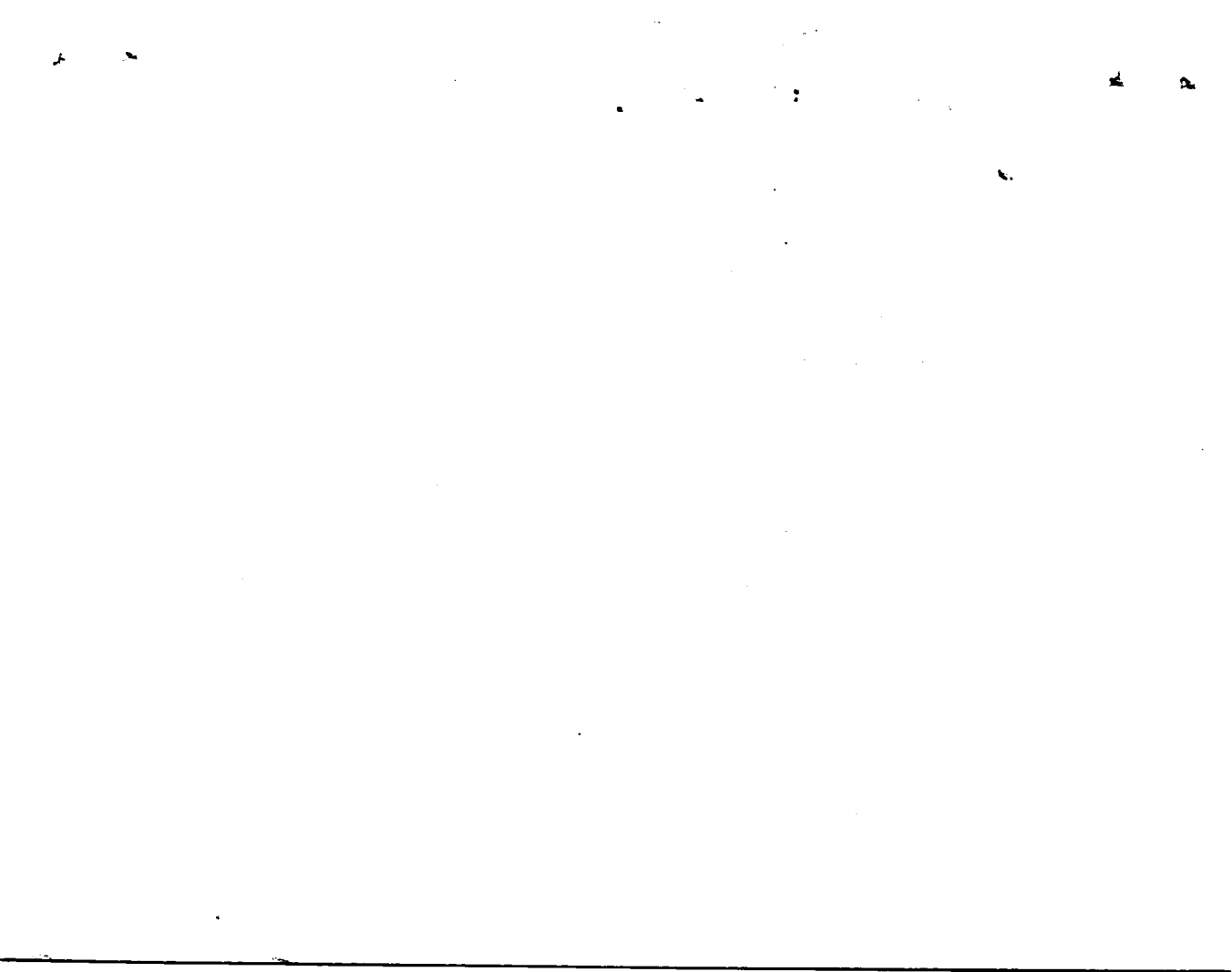
(Physician or midwife)

Address Gordium, Idaho

Filed 5/31

1929 J. A. Cromwell

Registrar.



FORM V. S. No. 5-25 M.

RECEIVED

JUN 6 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsI. PLACE OF DEATH,
County of Gooding
City of IdahoRegistration District No. 24-
Primary Registration District No. _____
(No. _____, _____ St.)File No. _____
Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed)

Bushby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Stillborn

6. DATE OF BIRTH

May 5- 1929
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Gooding Ida

10. NAME OF FATHER

Leslie Bushby

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Nellie Wisner

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Leslie Bushby
Richfield

15.

Filed

5/31- 1929

J. H. Cronwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn 5/5- 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - gest. period 9 mo
Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/6 1929

J. H. Cronwell M. D.

(Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding Ida 5/6 1929

20. UNDERTAKER

ADDRESS

W. A. Thompson Gooding Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1929

STATE OF IDAHO

County of Bentley
City of 552-119-024-355

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

171371

No. Goodling St.

Registration District No. 24 State File No. 363

(If born in hospital or institution give name.) Hospital

Prim. Registration District No. Antonia Local Registrar's No. 363

FULL NAME OF CHILD Unnamed Cruzusa Antonia
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u>	Legitimacy <u>yes</u>	Date of birth <u>5-10-</u> 19 <u>29</u> (Month) (Day) (Year)
-------------------------	---	-----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 7 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Gregoria Cruzusa

MOTHER
FULL MAIDEN NAME Emetea Leniga

Residence (Usual place of abode) Goodling

Residence (Usual place of abode) Goodling

If nonresident, give place and State Isla

If nonresident, give place and State Isla

Color or race white Age at last Birthday 41 (Years)

Color or race white Age at last Birthday 36 (Years)

Birthplace Spain (City and State or Country)

Birthplace Spain (City and State or Country)

Occupation farmer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M. on the date above stated.

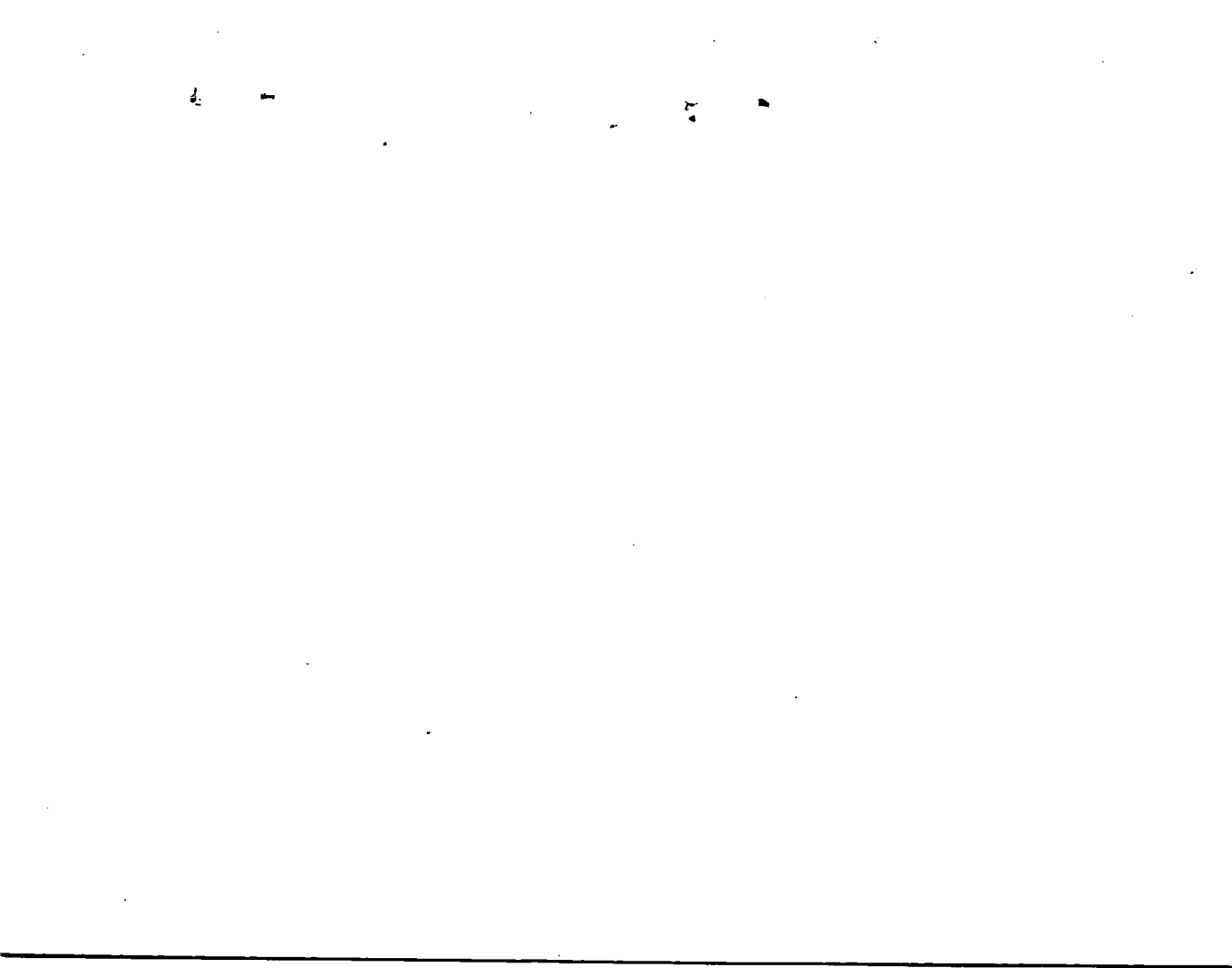
(Signature) J. H. Crummett M.D.

(Physician or midwife)

Address Goodling Isla

Filed 5/31 1929 J. H. Crummett Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUN 8 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of GoodingRegistration District No. 24City of Id

Primary Registration District No. _____

(No. _____ St.)

File No. _____

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed) Eusunsa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Stillborn

6. DATE OF BIRTH

5 - 10 - 29
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Gooding Ida

10. NAME OF FATHER

Gregoria Eusunsa

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Ematea Leniga

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ematea Eusunsa

(Address)

Gooding Ida

15.

Filed 5/31 - 1929J. H. Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn 5/10 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw h_____ alive on 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - gestation 9 Mo.
Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Cromwell M. D.5/11 1929 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding Ida 5/11 1929

20. UNDERTAKER

ADDRESS

A. B. Thompson Gooding Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1929

STATE OF IDAHO

County of Laurel

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Gardiner

CERTIFICATE OF BIRTH

No. 219-217-224-469

S 171377

Registration District No. 24 State File No. 360

(If born in hospital or institution give name.)

Prim. Registration District No. unassigned Local Registrar's No. 360

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>girl</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>3</u>	Legitimacy <u>yes</u>	Date of birth <u>5-17-1929</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 3

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Glenn Barker</u>	MOTHER FULL MAIDEN NAME <u>Frances R. Morris</u>
---	---

Residence (Usual place of abode) Gardiner

If nonresident, give place and State

Color or race white Age at last Birthday 33 (Years)

Birthplace Mo (City and State or Country)

Occupation Carpenter

Residence (Usual place of abode) Gardiner Id

If nonresident, give place and State

Color or race white Age at last Birthday 32 (Years)

Birthplace Idaho (City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 2 P. M. on the date above stated. } Stillborn

(Signature) J. H. Connors M.D.

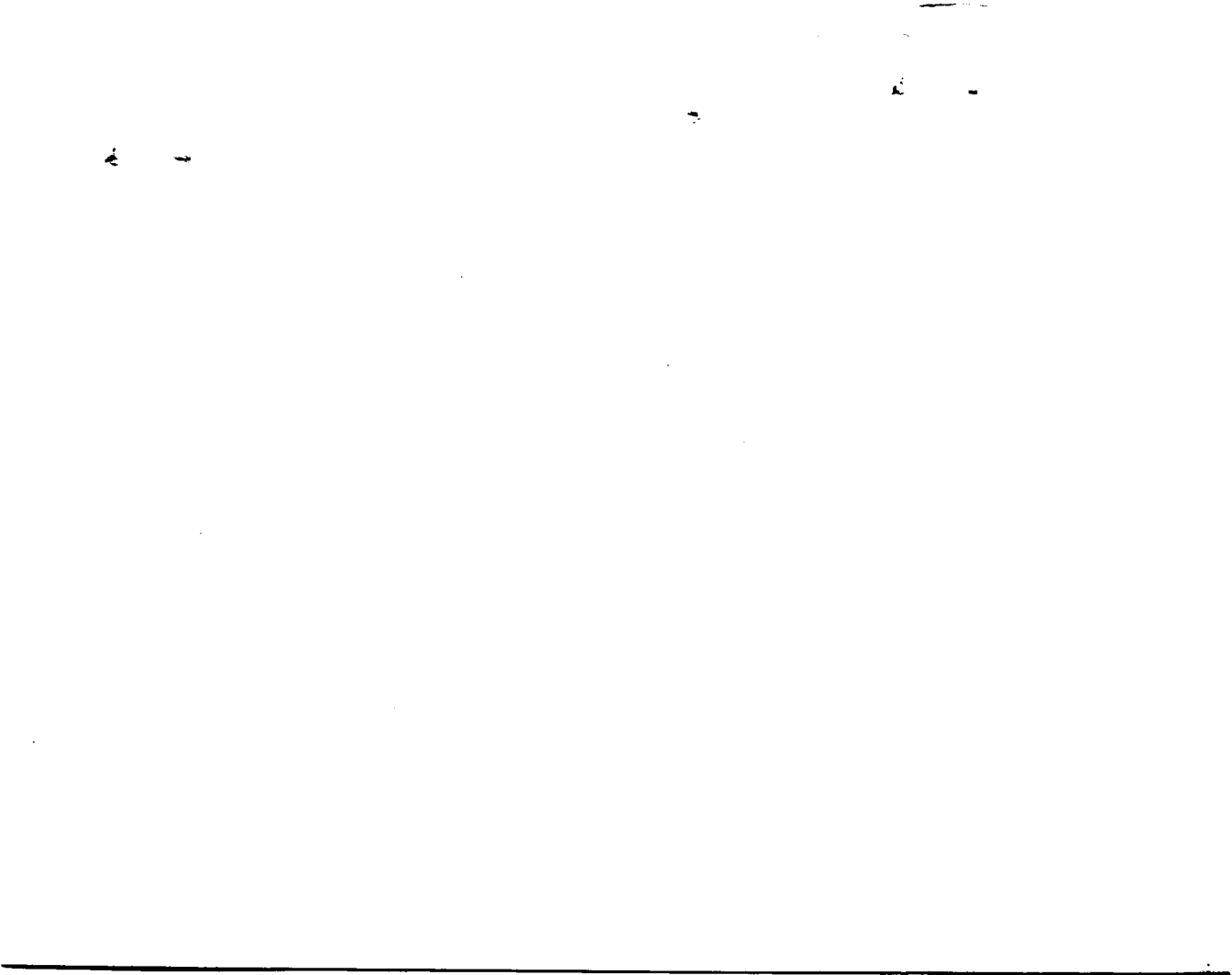
(Physician or midwife)

Address Gardiner Idaho

Filed 5/31-1929 J. H. Connors

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUN 6 1929 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Gooding
City of Gooding

Registration District No. 24

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed) Barker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 66285Registered No. 95

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

girl

4. COLOR OR RACE

white

5. SINGLE MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

5 - 17 - 29
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Gooding Ida

10. NAME OF FATHER

Glen Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Frances Morris

13. BIRTHPLACE OF MOTHER

(State or Country)

Calo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Glen Barker
(Address) Gooding Ida

15.

Filed 5/31 - 1929 JH Connors
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn 5 - 17 - 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn, gestation period
5 months cause unknown
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) JH Connors M. D.

5/8/29 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding Ida

DATE OF BURIAL

5/18/29

20. UNDERTAKER

AB Thompson

ADDRESS

Gooding Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs; meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

313-125225-863
PLACE OF BIRTH
County of Idaho
City of Grangeville
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

RECEIVED JUN 8 1929

171382-
1079

Registration District No. 103 State File No. _____

Birth Registration District No. 2181 Local Registrar's No. 16

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate?	Date of birth <u>May 25</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Platte Talbott
Residence (Usual place of abode) Grangeville Ida

MOTHER
FULL MAIDEN NAME Alberta Holbrook
Residence (Usual place of abode) Grangeville Ida

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 29
(Years)

Color or race white Age at last Birthday 27
(Years)

Birthplace Ida. Co. Ida.
(City and State or Country)

Birthplace Ida. Co. Ida.
(City and State or Country)

Occupation Farmer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6 A. M.
on the date above stated.

(Signature) B Chipman

(Physician or midwife)

Address Grangeville Ida.

Filed 6-1- 19 29 B Chipman

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

100 - 100

100 - 100

100 - 100

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **66231**

PLACE OF DEATH

County of Idaho

City of Munguilla

Registration District No. 103

Primary Registration District No. 2181

Local Registrar's No. 24

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME "Stillbirth"

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

RECEIVED JUN 8 1929

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Stillbirth

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 25-1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Platte Talbott

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida. Co. Idaho

12. MAIDEN NAME OF MOTHER Elberta Holbrook

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Co. Idaho

14. Informant Platte Talbott
(Address) Munguilla Idaho

15. Filed 6-1-29 B Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25-1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH was as follows:

Stillbirth Period of gestation about seven months

(duration) yrs. mos. ds.

CONTRIBUTORY Premature Separation
(Secondary)

7 Placenta (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) B Chipman, M. D.

5/26-1929 (Address) Munguilla Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Franklin Idaho 5-26-1929

20. Undertaker Address

Hamlock Mnd. Co. Munguilla Idaho

* A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

753-208-028-449
PLACE OF BIRTH
County of Boise MAY 30 1929
City of Harrison Ida
No. _____ St. _____
Registration District No. 126 State File No. 171420
(If born in hospital or institution give name.) Sacramento Hospital Prim. Registration District No. 2344 Local Registrar's No. 9-1727
FULL NAME OF CHILD Stillborn Elizabeth Pettet
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Female and Male (To be answered only in case of plural births)
Twin Single Triplet Other? Number in order of birth 1
Legitimate Yes Date of birth May 8 1929
(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? None
Number of child of this mother, including present birth 1st (a) Born alive and now living none
Born alive but now dead none Stillborn one
FATHER FULL NAME Kenneth L. Pettet MOTHER FULL MAIDEN NAME Kate Elizabeth Murray
Residence (Usual place of abode) Harrison Ida Residence (Usual place of abode) Harrison Ida
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race Caucasian Age at last Birthday 23 1/2 Color or race Caucasian Age at last Birthday 26 1/2
Birthplace Washington U.S.A. (Years) Birthplace Harrison Ida (Years)
(City and State or Country) (City and State or Country)
Occupation Saloon - bar tender Occupation Hv. Ex-school teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10 20 P. M.
on the date above stated. Stillborn

(Signature) H. R. Bankard
M.D.

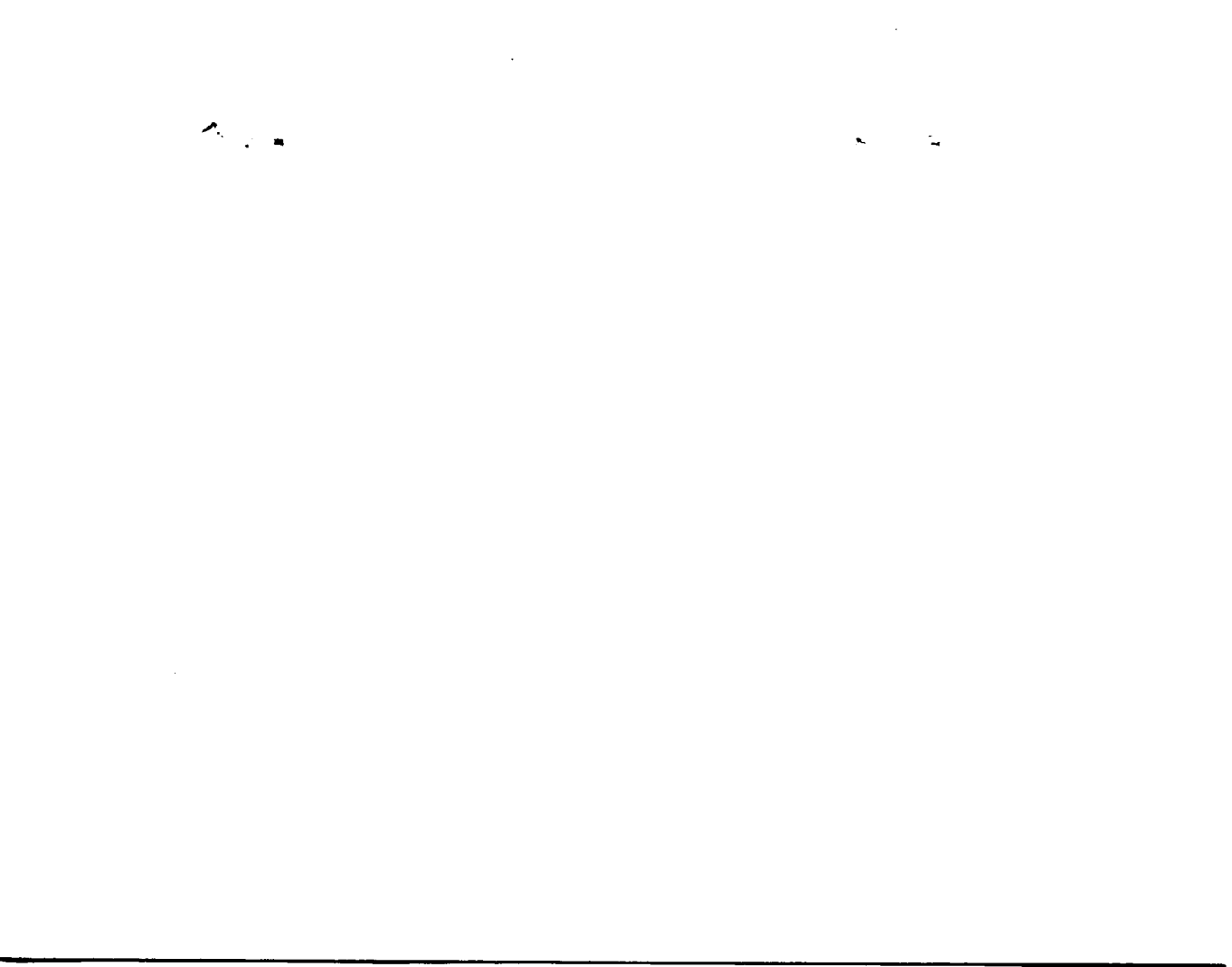
(Physician or midwife)

Address Harrison Ida

Filed 8-9-29 H. R. Bankard

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 30 1929

PLACE OF DEATH

County of *Posterni*

City of *Harrison Ida*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. *126*

Primary Registration District No. *2304*

DO NOT WRITE IN THIS SPACE

State File No. *68248*

Local Registrar's No. *4 1929*

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *(Stillborn)*

(a) Residence. No. *Elizabeth Pettet*

St. *206*

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *H*

4. COLOR OR RACE *Caucasian*

5. Single, Married, Widowed, or Divorced *Infant*

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *✓*

(b) General nature of industry, business, or establishment in which employed (or employer) *✓*

(c) Name of employer *✓*

9. BIRTHPLACE (city or town) *Harrison Ida*
(State or country)

10. NAME OF FATHER *Kenneth L Pettet*

11. BIRTHPLACE OF FATHER (city or town) *Washington*
(State or Country)

12. MAIDEN NAME OF MOTHER *Kate Elizabeth Murray*

13. BIRTHPLACE OF MOTHER (city or town) *Harrison Ida*
(State or Country)

14.

Informant *Mrs. Hattie L. Murray*

(Address) *Harrison Ida*

15.

Filed *5-9*

19 *29*

H.R. Bankard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 8 1929*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-8-

19 *29*

to

19 *29*

that *I saw her* alive, on *May 8*

and that death occurred, on the date stated above, at *10:30 P* m.

The CAUSE OF DEATH* was as follows: *Stillborn*

(duration) *✓* yrs. mos. ds.

CONTRIBUTORY (Secondary) *✓*

18. Where was disease contracted? *Beach, Washington & forced delivery*
if not at place of death?

Did an operation precede death? *NO*

Date of *✓*

Was there an autopsy? *NO*

What test confirmed diagnosis? *✓*

(Signed) *H.R. Bankard*

M. D.

5-9, 19 *29* (Address) *Harrison Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Harrison County*

Date of Burial.

5-9 1929

20. Undertaker *Family*

Address *Harrison Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

317-107-528-249
PLACE OF RECEIVED MAY 30 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
S
171421

County of Kootenai
City of Harrison
No. _____ St. _____
Registration District No. 126 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2304 Local Registrar's No. 8-1929

FULL NAME OF CHILD Stillborn Carbon
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin <u>Single</u> and <u>Number in order of birth</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>May 3rd</u> 19 <u>29</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 10th (a) Born alive and now living 8
Born alive but now dead one Stillborn one

FULL NAME <u>Edward A. Carbon</u> FATHER	FULL MAIDEN NAME <u>Claudia Anne Smith</u> MOTHER
Residence (Usual place of abode) <u>Kan Enaville, Ida</u>	Residence (Usual place of abode) <u>Kan Enaville, Ida</u>
If nonresident, give place and State <u>L</u>	If nonresident, give place and State <u>L</u>
Color or race <u>Caucasian</u> Age at last Birthday <u>55</u> (Years)	Color or race <u>Caucasian</u> Age at last Birthday <u>35</u> (Years)
Birthplace <u>Minneapolis</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>H.W.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12:10 Am, M.
on the date above stated. (Signature) H.R. Bankard

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Harrison, Ida
Filed 5-3 19 29 H.R. Bankard
Registrar.

1

2

3

4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 30 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

86246

State File No.
Local Registrar's No. 3-1929

PLACE OF DEATH
County of Kootenai
City of Harrison Ida
Registration District No. 126
Primary Registration District No. 2304

(No.)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Unnamed Carlson (Stillborn)
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. Single Married Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ✓
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Harrison Ida

10. NAME OF FATHER Edmund A Carlson
55 yrs

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Claudia Mc Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin
35 yrs

14. Mrs Claudia P. Carlson
Informant
(Address) Emerville Ida

Filed 5-3, 19 29 H R Bankard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3rd 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd 1929 12:30 AM, 19 29

that I last saw him alive, on, 19 29
and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows: Stillbirth
Cause of
Don't know.

(duration) yrs. mos. ds.
CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted ✓
If not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?
(Signed) H R Bankard M. D.
5-3, 19 29 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison County Date of Burial 5-3 1929

20. Undertaker Family (Mc Smith) Address Harrison Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

349-1920-28-294
PLACE OF BIRTH RECEIVED JUN 8 1929 STATE OF IDAHO

County of Kootenai
City of Ratholun
No. _____ St.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 171433

Registration District No. 30 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 1050 Local Registrar's No. 96

FULL NAME OF CHILD (unnamed) Curtis (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>1st</u>	Date of birth <u>May 30, 1929</u> (Month) (Day) (Year)
--------------------------	---	-----	---	--	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living None

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME William N. Curtis

MOTHER
FULL MAIDEN NAME Gladys F. Simmet

Residence (Usual place of abode) Carewood, Ida.

Residence (Usual place of abode) Carewood, Ida.

If nonresident, give place and State _____

If nonresident, give place and State Idaho

Color or race white Age at last Birthday 39
(Years)

Color or race white Age at last Birthday 18
(Years)

Birthplace Idaho
(City and State or Country)

Birthplace Spokane, Wash.
(City and State or Country)

Occupation laborer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

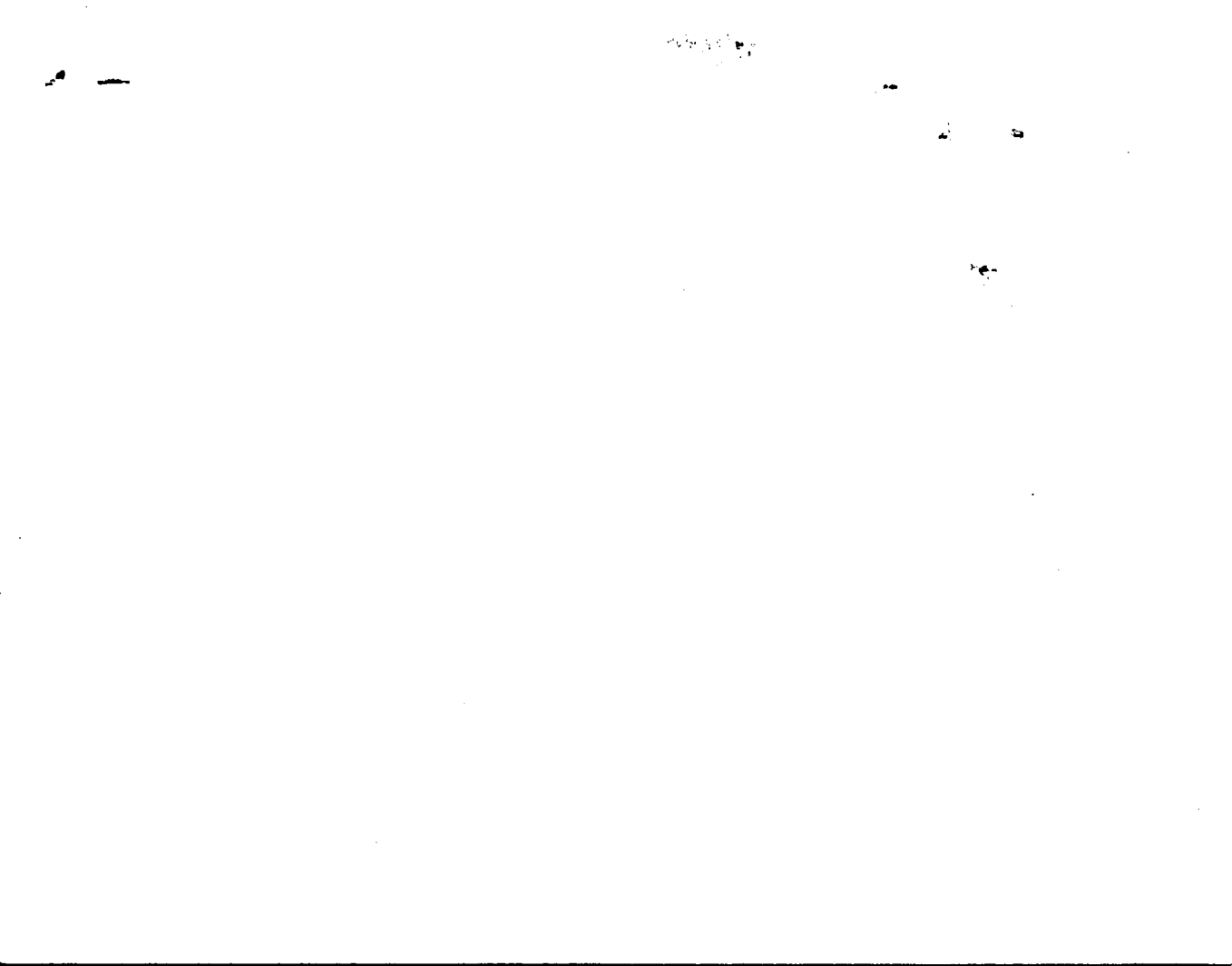
I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 P. M.
on the date above stated.

(Signature) Frank Harris
Physician or midwife

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Ratholun, Idaho

Filed June 5, 1929 H. J. Sturges
Registrar.



RECEIVED AUG 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **66993**

PLACE OF DEATH

County of KootenaiCity of BoothdunRegistration District No. 30Primary Registration District No. 1050Local Registrar's No. 10(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby (Not named) Curtis

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) -5a. ☒ married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) May 30, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Boothdun
(State or country) Idaho10. NAME OF FATHER W. G. Curtis11. BIRTHPLACE OF FATHER (city or town) Seattle
(State or Country) Washington12. MAIDEN NAME OF MOTHER Blaise Emmett13. BIRTHPLACE OF MOTHER (city or town) Plymouth Lake
(State or Country) Washington14. Informant W. N. Curtis
(Address) Boothdun, Idaho15. Filed 7/24, 1929, H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

(was stillborn), to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

intra-uterine, about 2
weeks before birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Frank P. King, M. D.5731, 1929. (Address) Boothdun, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pine Grove Cemetery, Boothdun Date of Burial 6/1, 192920. Undertaker Cassidy Funeral Home Address Boothdun

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown**.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH *Minnesota* **MINN** STATE OF MINN
County *Hennepin* DEPARTMENT OF PUBLIC WELFARE
City of *Post Falls* BUREAU OF VITAL STATISTICS
No. *255-249-24-27* St. Registration District No. *58* State File No. *171442*

Hospital _____ Primary Registration District No. *1050* Local Registrar's No. *85*
FULL NAME OF CHILD *unnamed Kenig* *171442 S*
(Certificate of no value without full name of child)

Sex of Child *Female* Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? *yes* Date of birth *May 19 1929*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth *10* Number of child of this mother now living, including present birth *8*

FATHER
FULL NAME *J. A. Kenig*
RESIDENCE *Post Falls*
COLOR *white* AGE AT LAST BIRTHDAY *40*
(Years)
BIRTHPLACE *Kan*
OCCUPATION *Common Laborer*

MOTHER
FULL MAIDEN NAME *Analle Black*
RESIDENCE *Post Falls*
COLOR *white* AGE AT LAST BIRTHDAY *50*
(Years)
BIRTHPLACE *Mo*
OCCUPATION *House Keeper*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Boys* *Stillborn* at *11:45* *A* M.
on the date above stated.

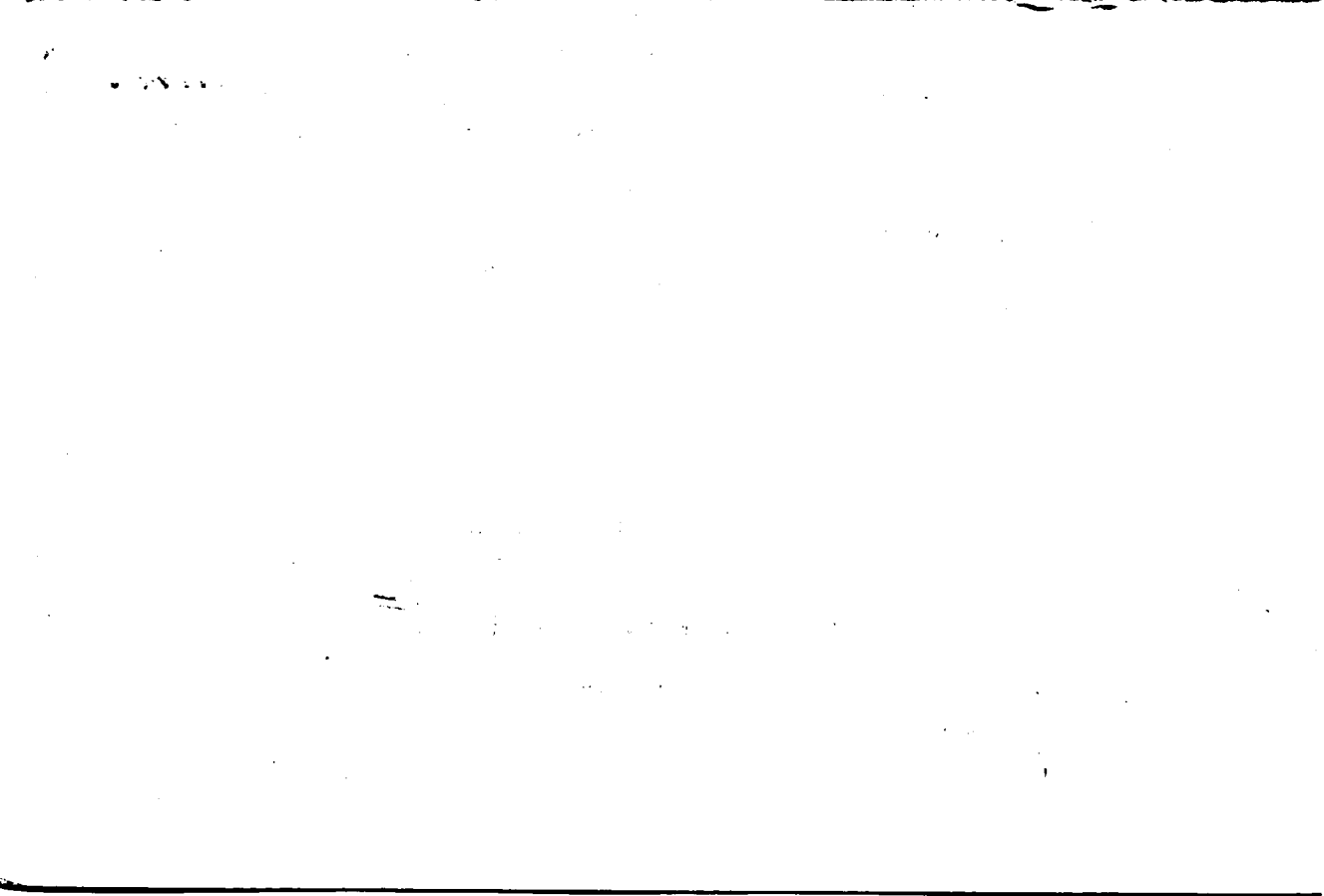
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) *F. L. McCarley*

(Physician or midwife)
Address *Post Falls, Ida*

Filed *May 20 1929* *H. J. Sturges*
Registrar. Registrar.



RECEIVED

JUN 8

1929

CERTIFICATE OF DEATH

1. - PLACE OF DEATH

County of *Post Falls*
City of *Post Falls*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *50*Primary Registration District No. *1050*

(No. St.)

2. FULL NAME

Un-named

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. *75*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 19 1929
(Month) (Day) (Year)

7. AGE

Still-born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

Post Falls, Ida
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

I. A. Kening
Kan
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

Amalee Black
Mo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *I. A. Kening*(Address) *Post Falls, Ida*

15.

Filed *May 27* 1929

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 1929 to *May 19 1929*that I last saw him *Still-born* 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still-born

.....

..... (Duration) Yrs. mos. ds.

Contributory (Secondary)

..... (Duration) Yrs. mos. ds.

(Signed) *J. McCaulley* M. D.*May 20 1929* (Address) *Post Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

May 20 1929

20. UNDERTAKER

J. A. Kening *Post Falls Ida*

MARGIN RESERVED FOR BINDING

171642-7 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum, etc., Carcinoma, Sarcoma, etc., of* (true origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Monstrosities; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

693-118030-295
PLACE OF RECEIVED JUN 13 1929

County of Sevier
City of Tenney
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

171493

Registration District No. 41 State File No. _____
Prim. Registration District No. 2116 Local Registrar's No. _____

FULL NAME OF CHILD Seebirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>m.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>April 18</u> 19 <u>29</u> (Month) (Day) (Year)
------------------------	---	--------------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Wm Mc Laughlin Wilson
Residence (Usual place of abode) Myers Cove
If nonresident, give place and State _____
Color or race white Age at last Birthday 29 (Years)
Birthplace Salt Lake City Utah (City and State or Country)
Occupation Ranchman

MOTHER
FULL MAIDEN NAME Abelle Fay Kingsbury
Residence (Usual place of abode) Myers Cove
If nonresident, give place and State _____
Color or race white Age at last Birthday 25 (Years)
Birthplace Idaho (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 6 A M.

(Signature) Charles F. Hamme M.D.

(Physician or midwife)

Address Idaho

Filed 6-10 1929 Clara Bellamy
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

955-118-033-269

PLACE OF RECEIVED

JUN 10 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 171518

County of Madison
City of Rexburg
No. _____ St. _____

Registration District No. 100 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2178 Local Registrar's No. 118

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5</u> / <u>18</u> / <u>1929</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercurio Chromo

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Fred W. Reese
Residence (Usual place of abode) Rexburg
If nonresident, give place and State _____
Color or race White Age at last Birthday 20 (Years)
Birthplace Utah (City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Teresa Swinyard
Residence (Usual place of abode) Rexburg
If nonresident, give place and State _____
Color or race White Age at last Birthday 30 (Years)
Birthplace Utah (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at _____ on the date above stated.

(Signature) Lois E. Nash

(Physician or midwife)

Address Rexburg Idaho

Filed 77 1929 W. Young Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



STATE OF IDAHO		DEPARTMENT OF PUBLIC WELFARE	
BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS	
<div style="float: right; border: 1px solid black; padding: 5px;"> DO NOT WRITE IN THIS SPACE 66292 </div>			
RECEIVED JUN 10 1929 PLACE OF DEATH		CERTIFICATE OF DEATH	
County of <u>Madison</u>	Registration District No. <u>100</u>	Local Registrar's No. <u>41</u>	
City of <u>Reclung</u>	Primary Registration District No. <u>2178</u>		
(No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)			
2. FULL NAME <u>Kill Bon</u>			
(a) Residence. No. _____ St. _____		(If nonresident give city or town and State)	
(Usual place of abode)			
Length of residence in city or town where death occurred. yrs. mos. ds.		How long in U. S., if of foreign birth? yrs. mos. ds.	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>	
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____			
6. DATE OF BIRTH (month, day and year) <u>May 18 1929</u>			
7. AGE Years _____	Months _____	Days _____	If LESS than 1 day, hrs. or min. _____
8. OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work <u>Still Bon</u>			
(b) General nature of industry, business, or establishment in which employed (or employer) _____			
(c) Name of employer _____			
9. BIRTHPLACE (city or town) <u>Reclung Idaho</u> (State or country)			
10. NAME OF FATHER <u>Freddy W Reese</u>			
11. BIRTHPLACE OF FATHER (city or town) <u>Beaumont Utah</u> (State or Country)			
12. MAIDEN NAME OF MOTHER <u>Orissa Swingard</u>			
13. BIRTHPLACE OF MOTHER (city or town) <u>Lewiston Utah</u> (State or Country)			
14. Informant <u>John J. Reese</u> (Address) <u>Reclung</u>			
15. Filed <u>5/19</u> 19 <u>29</u> <u>J. Payson</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH <u>May 18</u> 19 <u>29</u> (Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from <u>May 18</u> 19 <u>29</u> , to <u>May 18</u> 19 <u>29</u> that I last saw him <u>Still Bon</u> 19 <u>29</u> and that death occurred, on the date stated above, at <u>8 PM</u> m. The CAUSE OF DEATH* was as follows: <u>Still Bon</u>			
CONTRIBUTORY (Secondary) <u>Strangulated hernial Cord</u> (duration) _____ yrs. _____ mos. _____ ds.			
18. Where was disease contracted <u>✓</u> if not at place of death? <u>✓</u> Did an operation precede death? <u>✓</u> Date of <u>✓</u> Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>findings</u> (Signed) <u>James A. Fisher</u> M. D. <u>5/19</u> 19 <u>29</u> (Address) <u>Reclung Idaho</u>			
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
19. Place of Burial, Cremation, or Removal <u>Reclung City</u>		Date of Burial <u>May 19</u> 19 <u>29</u>	
20. Undertaker _____		Address _____	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238-212-037-199
PLACE OF BIRTH RECEIVED JUN 8 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Montana
CITY OF Paul
No. St.
CERTIFICATE OF BIRTH
S 171525
Registration District No. 19 State File No. 171525
(If born in hospital or institution give name.)
Prim Registration District No. 2015 Local Registrar's No. 89

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>girl</u>	Twins or other? <u>Triplet</u>	and { Number in order of birth of birth (To be answered only in event of plural births) }	Legitimate? <u>yes</u>	Date of birth <u>5</u> <u>12</u> <u>1919</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 13 (a) Born alive and now living 10
Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME <u>John Schiedt</u>	FULL MAIDEN NAME <u>Julia Arrows</u>
Residence (Usual place of abode) <u>Paul</u>	Residence (Usual place of abode) <u>Paul</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday <u>47</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)
Birthplace <u>Russia</u> (City and State or Country)	Birthplace <u>Russia</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 10:30 P. M. on the date above stated.

(Signature) J. B. Kenney
Physician
(Physician or midwife)

Address Robert Id.

Filed 5-31-1929 E. B. Elmer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1000

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

769-224-034-319
PLACE OF BIRTH RECEIVED JUN 8 1929
STATE OF IDAHO
County of Minidoka
City of Rupert
No. _____ St. _____
Registration District No. 19 State File No. S 171527
(If born in hospital or institution
give name.)
Prim. Registration District No. 2013 Local Registrar's No. 82

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>5 24 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Arthur Gordon</u>	MOTHER FULL MAIDEN NAME <u>Mary Campbell</u>
--	---

Residence (Usual place of abode) <u>Rupert</u>	Residence (Usual place of abode) <u>Rupert</u>
--	--

If nonresident, give place and State <u>Idaho</u>	If nonresident, give place and State <u>Idaho</u>
---	---

Color or race <u>white</u> Age at last Birthday <u>25</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)
---	---

Birthplace <u>Kansas</u> (City and State or Country)	Birthplace <u>Ark</u> (City and State or Country)
--	---

Occupation <u>Clark</u>	Occupation <u>housewife</u>
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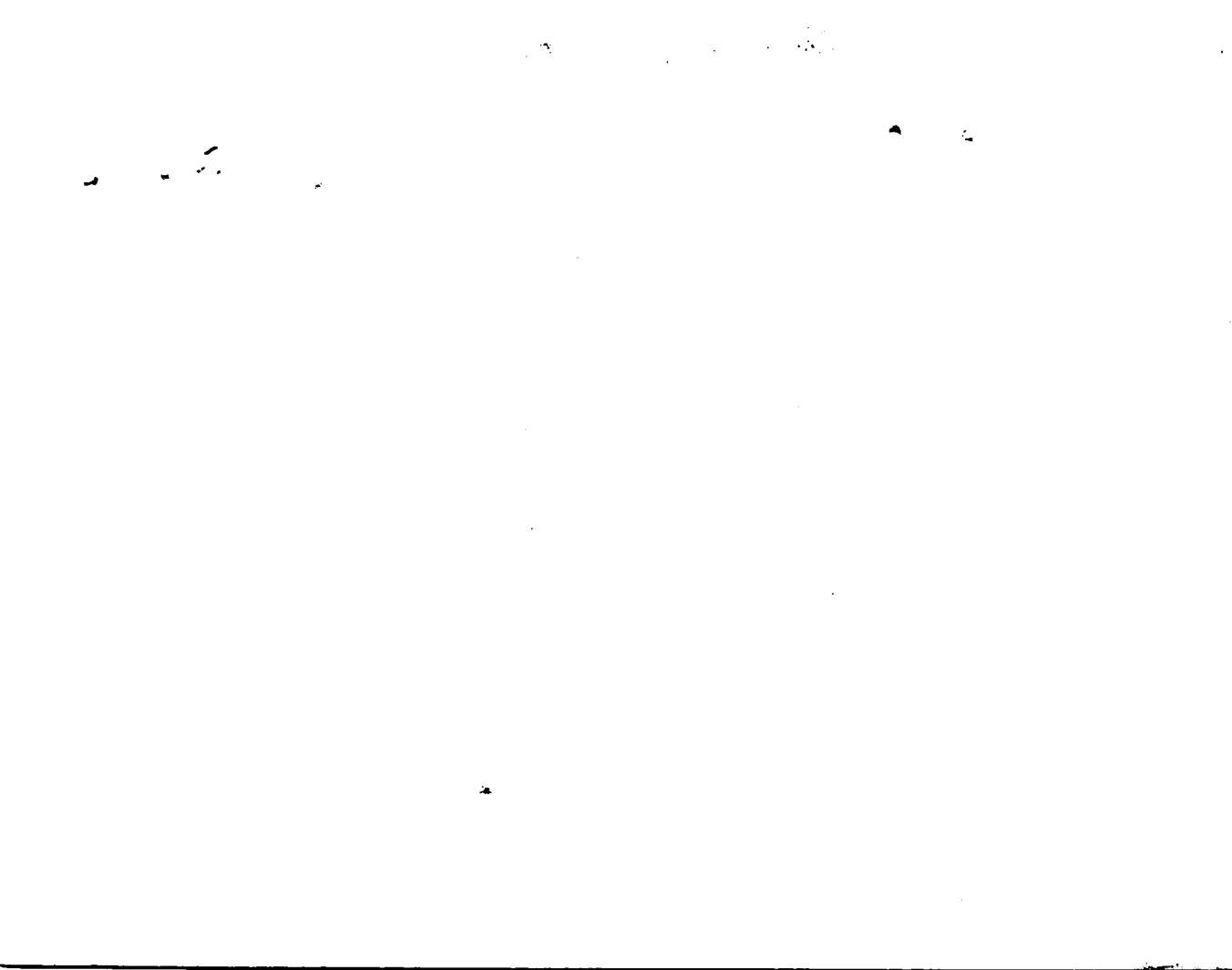
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8 A.M. M.
on the date above stated.

(Signature) Layne A. Kenney MD
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Rupert
Filed 2-29 1929 E. H. Elmore
Registrar.



FORM V. S. 1-19

RECEIVED SEP 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Minidoka*
City of *Reupert*Registration District No. *19*
Primary Registration District No. *2015*
(No. _____, _____ St.)File No. *73*
Registered No. *87377*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(State the word.)

6. DATE OF BIRTH

May 24 1929
(Month) (Day) (Year)

7. AGE

— Yrs. *—* Mos. *—* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Child*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur Gordon

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Nilla Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Perry Gordon
Reupert Idaho

15.

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____,

that I last saw him _____ alive on _____ 19 _____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Kennedy M. D.*8-29-1929* (Address) *Reupert Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reupert Cemetery *May 24 1929*

20. UNDERTAKER

ADDRESS

W. A. Gordon *Reupert Idaho*

SA stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

693-110-025-386
PLACE OF BIRTH NEZ PERCE
COUNTY OF NEZ PERCE
CITY OF Southwick
No. _____ St. _____
At home
(If born in hospital or institution give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
171537
Registration District No. 63 State File No. _____
Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth Wittman
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Male	Twin No	and	Number in order of birth 0	Legitimate?	Date of birth April 10, 1929
Child	Triplet or other?		(To be answered only in event of plural births)		(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Not needed

Number of child of this mother, including present birth 10 (a) Born alive and now living 7
Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME Frank W. Wittman	FULL MAIDEN NAME Lydia Thomas
Residence (Usual place of abode) Southwick, Ida	Residence (Usual place of abode) Southwick
If nonresident, give place and State	If nonresident, give place and State
Color or race White Age at last Birthday 46	Color or race White Age at last Birthday 36
Birthplace Wisconsin (City and State or Country)	Birthplace Missouri (City and State or Country)
Occupation Farmer	Occupation Housewife

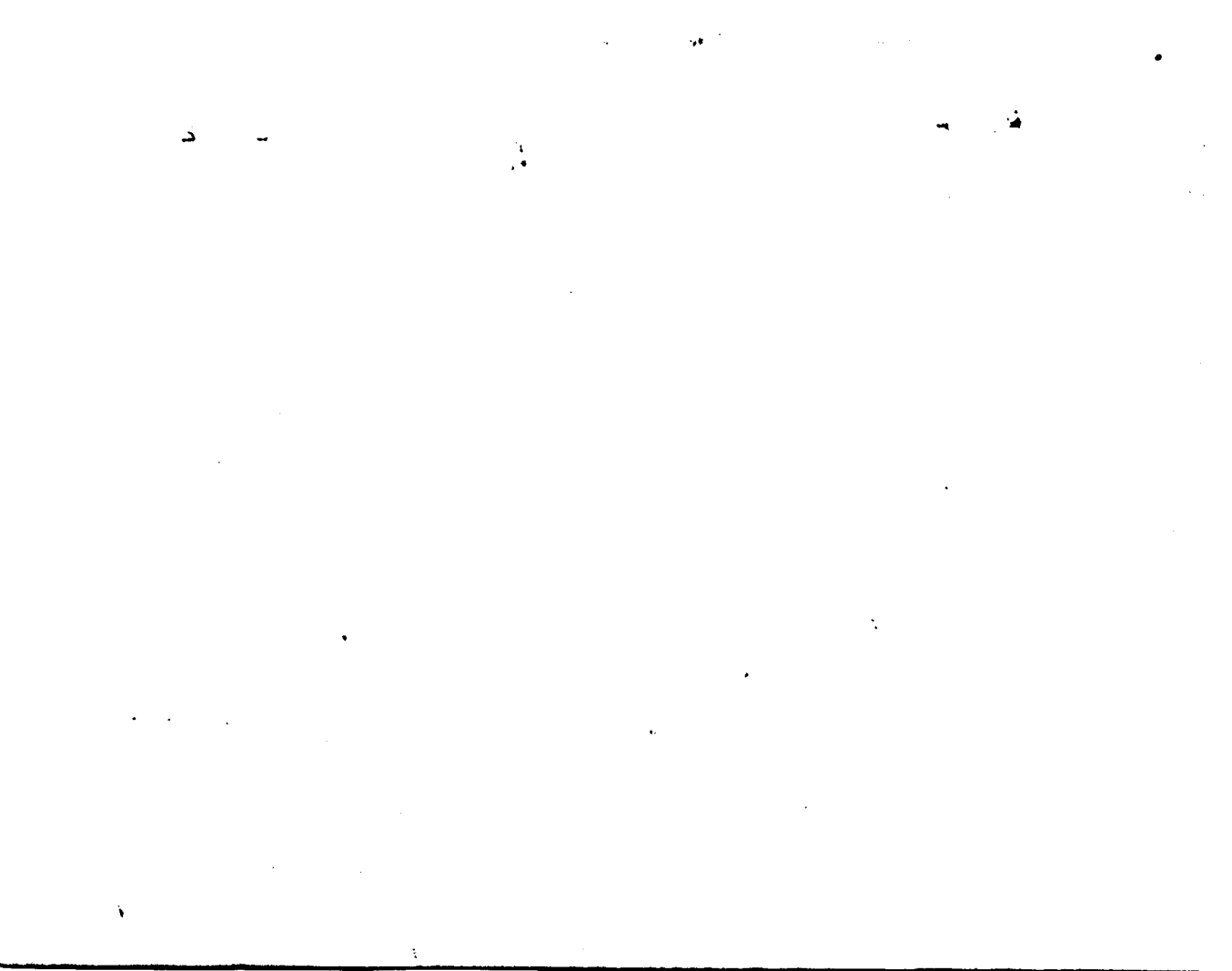
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2.20 P.M.
on the date above stated.

(Signature) Olney M. Mearns M.D.
Physician
(Physician or midwife)

Address Kendrick, Idaho.
Filed Apr. 15 1929 P. F. Nesbit.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUN 12 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

86274

State File No.

PLACE OF DEATH

County of Nez Perce
City of Southwick

CERTIFICATE OF DEATH

Registration District No. 63
Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby (Stillborn) Wittman

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Infant5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) April 10, 19297. AGE Years Months Days stillbirth
If LESS than 1 day, min. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Southwick (rural)
(State or country)10. NAME OF FATHER Frank Wittman11. BIRTHPLACE OF FATHER (city or town) Wisconsin
(State or Country)12. MAIDEN NAME OF MOTHER Lydia Thomas13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)14. Informant Frank Wittman
(Address) Southwick, Idaho.15. Filed June 1, 1929 B.F. Nesbit.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10, 1929, to, 19.....

that I last saw him alive on, 19.....

and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Stillborn.Meconium appeared about 10 min.before delivery. Umbilical cordwrapped tightly around neck
(duration) yrs. mos. ds.twice. Conditions normal inCONTRIBUTORY (Secondary) other respects.

(duration) yrs. mos. ds.

18. Where was disease contracted

if not at place of death? NoDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Oliver Morehead, M. D.(Signed) Oliver MoreheadApril 12, 1929 (Address) Kendrick, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Southwick, Ida.Date of Burial
Apr 11 1929 19

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull**, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

362-117,240-692

PLACE OF BIRTH

RECEIVED

MAY 15

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 171603

County of Shoshone

City of Walla Walla

No. _____ St. _____

Walla Walla, Wyo.

(If born in hospital or institution
give name.)

Registration District No. 76 State File No. _____

Prim. Registration District No. 1011 Local Registrar's No. 90

FULL NAME OF CHILD

Stillbirth

If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>4-15-1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 1

FATHER

FULL NAME Charles H. Croston

Residence (Usual place of abode) Burke, Ida

If nonresident, give place and State Kosci, Ida

Color or race White Age at last Birthday 22
(Years)

Birthplace Pullman, Wn.
(City and State or Country)

Occupation Manager & Miner

MOTHER

FULL MAIDEN NAME Delpha Fisher

Residence (Usual place of abode) Burke, Ida

If nonresident, give place and State Kosci, Ida

Color or race White Age at last Birthday 19
(Years)

Birthplace Western Neb.
(City and State or Country)

Occupation H.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 15 P. M.
on the date above stated.

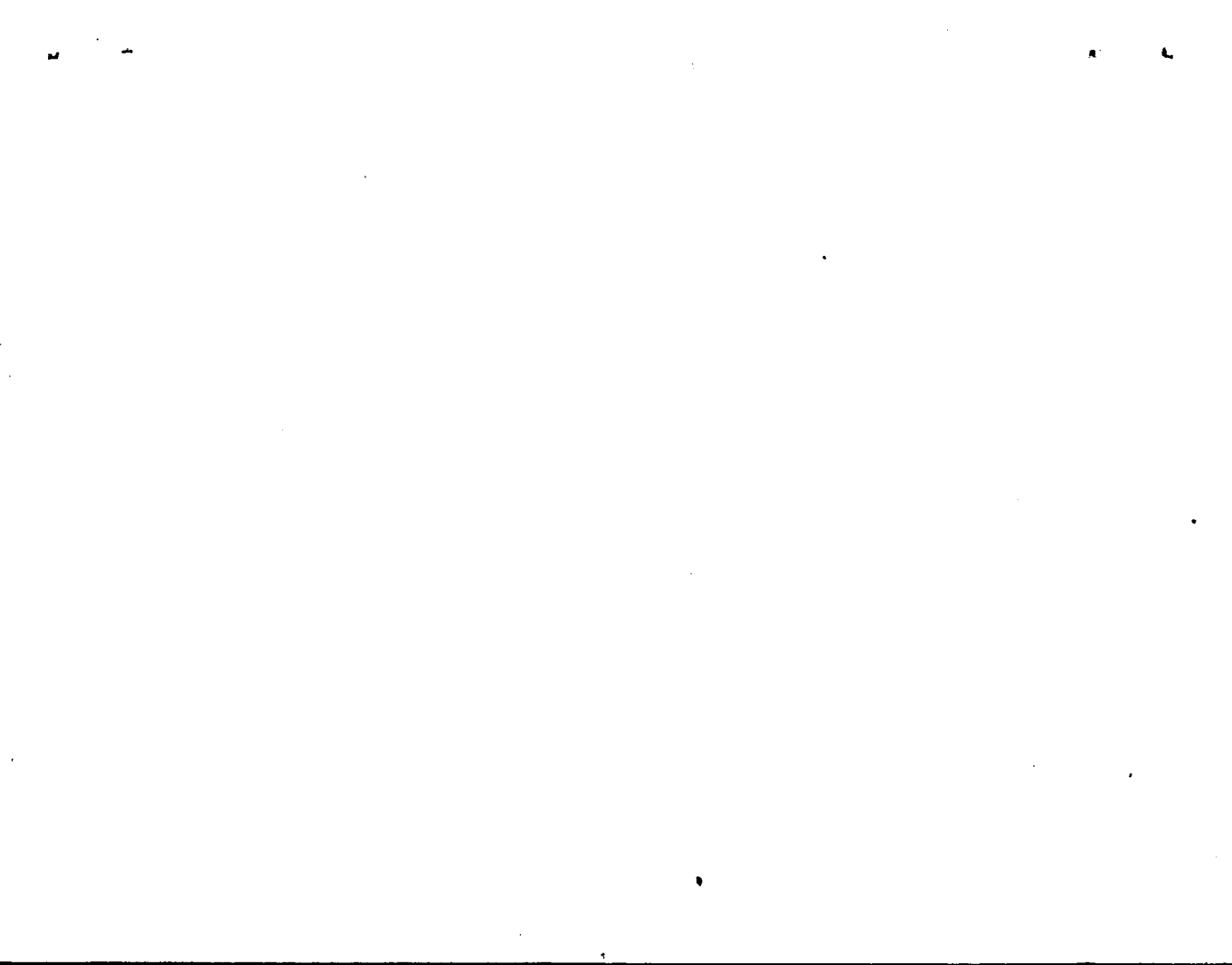
(Signature) W. H. Werlich

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed Apr 16 1929 G. K. Zinsley
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **86323**

PLACE OF DEATH **Shoshone**
County of **Wallace**
City of **Wallace**

Registration District No. **70**
Primary Registration District No. **1011**
(No. **Wallace Hospital**)

Local Registrar's No. **40**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Infant Boston**
(a) Residence. No. **Burke, Idaho** St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) Stillborn		
7. AGE —	Years —	Months —
		Days —
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho
10. NAME OF FATHER Chas. D. Boston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho, Wyo.
12. MAIDEN NAME OF MOTHER Delpha Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ore.

14. Informant (Address) C. D. Boston Burke, Idaho
15. Filed Apr 14 , 1929 J. H. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13 , 19 29 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 13 , 19 29 , to April 13 , 19 29 , that I last saw him alive on April 13 , 19 29 , and that death occurred, on the date stated above, at 6: P. m. The CAUSE OF DEATH* was as follows: Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Did an operation precede death? no Date of Was there an autopsy? no What test confirmed diagnosis? physical examination (Signed) Wallace, Idaho , M. D. April 15 , 19 29 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho	Date of Burial Apr 14 , 19 29
20. Undertaker Ward Undertaking Co.	Address Wallace, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

449-111-012-714
PLACE OF BIRTH
County of Linn
City of Linn
No. 752 St.

RECEIVED JUN 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S171645

Registration District No. 37 State File No. _____

Prim. Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Clarence Murphy
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mately <u>yes</u>	Date of birth <u>May 11</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	---	------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Walter C. Murphy

Residence (Usual place of abode) Berger, Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 42 (Years)

Birthplace Ucola Iowa

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Alma Jackson

Residence (Usual place of abode) Berger, Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 33 (Years)

Birthplace White River, S.D.

(City and State or Country)

Occupation Teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was {Stillborn} at 10 pm M.
on the date above stated.

(Signature) H. W. Wilson M.D.

(Physician or midwife)

Address Linn Falls, Idaho

Filed 6-10 1929 H. N. Lids

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CHIEF INVESTIGATOR OF MURDER

CONFIDENTIAL

CLINTON TO CHAMBERLAIN

1240

What people have to do is to get out of the way of the people who are going to do the work.

add to B3 to reduce

SUMMARY

5112
25640

(which is also type 3) described

100-443887-100

(b)(7)(C)

(Only use state or country)

SECRET

RECEIVED BY THE DIRECTOR, FBI, 10/10/54

1. 1950-1954

I hereby certify that I attended the birth of this child, who was delivered on the date above stated.

(S10-11437)

There were no attending physicians on duty with the patient on the night of the attack. A physician should make the report. A physician should be one that neither doctor nor other evidence of the patient.

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66354

County of Twin Falls
City of Twin Falls

Registration District No. 12
Primary Registration District No. 12

Local Registrar's No. 206

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarence Murphy

(a) Residence. No. Burton Idaho St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) 5-11-29

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Walter C. Murphy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Alma Paulson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Dakota

14. Informant Walter C. Murphy (Address) Burton Ida

15. Filed 7-10, 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 11 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11, 1929, to May 11, 1929
that I last saw him alive on _____

and that death occurred, on the date stated above, at 5/11-10pm in _____

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Wilson, M. D.

May 12, 1929 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls 5-13 1929

20. Undertaker

Address

White Mortuary Twin Falls
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-105-047-685

PLACE OF BIRTH RECEIVED

JUN 10 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

171665

County of Twin Falls

City of Twin Falls

No. _____ St. _____

T. F. Co. & Gen.

(If born in hospital or institution give name.)

Registration District No. 37 State File No. _____

Prim. Registration District No. 108 Local Registrar's No. _____

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>May 5</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Frank E. Martin</u>	FULL MAIDEN NAME <u>Diana Wynne</u>

Residence (Usual place of abode) 506-3 Ave E

If nonresident, give place and State _____

Color or race W Age at last Birthday 26 (Years)

Birthplace _____ (City and State or Country)

Occupation mechanic

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ on the date above stated. 3²⁰ 10 M.

(Signature) J. H. [Signature]

(Physician or midwife)

Address Twin Falls

Filed 6-10 1929 H. N. Lee

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Local Registration District No. _____

If born in hospital or institution
Give name

FULL NAME OF CHILD

If stillborn, indicate the word "stillborn" in name of child

Child	Sex of	Color of	Weight	Length	Date of Birth
(To be answered only in event of normal birth)	Male or Female	White, Black, or other	In pounds	In inches	(Month, Day, Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth (a) Born alive and now living

Born alive and now living

FATHER	MOTHER
NAME	NAME
DATE	DATE

Residence (last place of abode)

If nonresident, give place and State

Color of hair

Birthplace (City and State or Country)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was a stillborn (a) _____

(Signature)

(Physician or midwife)

Address

When

*Where there was no attending physician or midwife, then the father, grandmother, etc. should make this return. A stillborn child is one that neither breathes nor shows signs of life after birth.

RECEIVED BY THE STATE OF IDAHO
BUREAU OF VITAL STATISTICS
JAN 10 1934

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

65986

State File No.

Local Registrar's No.

PLACE OF DEATH
County of Lewis & Clark
City of _____Registration District No. 37Primary Registration District No. 1225

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed male child

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of ✓
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Still born Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Lewis & Clark Idaho
(State or country)10 NAME OF FATHER Frank E. Martin11 BIRTHPLACE OF FATHER (city or town) Kebo Wash
(State or country)12 MAIDEN NAME OF MOTHER Gonna Wynne13 BIRTHPLACE OF MOTHER (city or town) Yakima Wash
(State or country)Informant Mrs. Gonna Martin
(Address) Lewis & Clark Idaho15 Filed 5-10 19 29 H. H. Luke
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 5th 19 29
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from May 5th 19 29, to May 5th 19 29, that I last saw him alive on _____, 19 _____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still-born at 8 mos. gestation

CONTRIBUTORY (Secondary)

Premature detachment of placenta + rupture of membranes
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? Yes Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Lippert M. D.
5-7 19 29 (Address) Lewis & Clark Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Lewis & Clark Cem. 5-6 19 29

20. Undertaker

Address

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of **RECEIVED JUL 6 1929**

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of

CERTIFICATE OF BIRTH

No. St.

692-129-001-993

Registration District No. **2**

State File No. **171732**

(If born in hospital or institution
give name.)

Prim. Registration District No. **1004**

Local Registrar's No. **227**

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? y	Date of birth 5 29 1929 (Month) (Day) (Year)
-----------------------	---	-------	--------------------------------	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn

FATHER
FULL NAME **Chas Fisk**

MOTHER
FULL MAIDEN NAME **Edna Marie Richardson**

Residence (Usual place of abode) **Eagle, Ida**

Residence (Usual place of abode) **Idaho**

If nonresident, give place and State **St. Louis, Mo.**

If nonresident, give place and State **Idaho**

Color or race **W** Age at last Birthday **28**
(Years)

Color or race **W** Age at last Birthday **23**
(Years)

Birthplace **Idaho**
(City and State or Country)

Birthplace **Wash.**
(City and State or Country)

Occupation **Farmer**

Occupation **Phys.**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at **904 P.** M.
on the date above stated. { Stillborn }

(Signature) **A. J. Coats, M.D.**

(Physician or midwife)

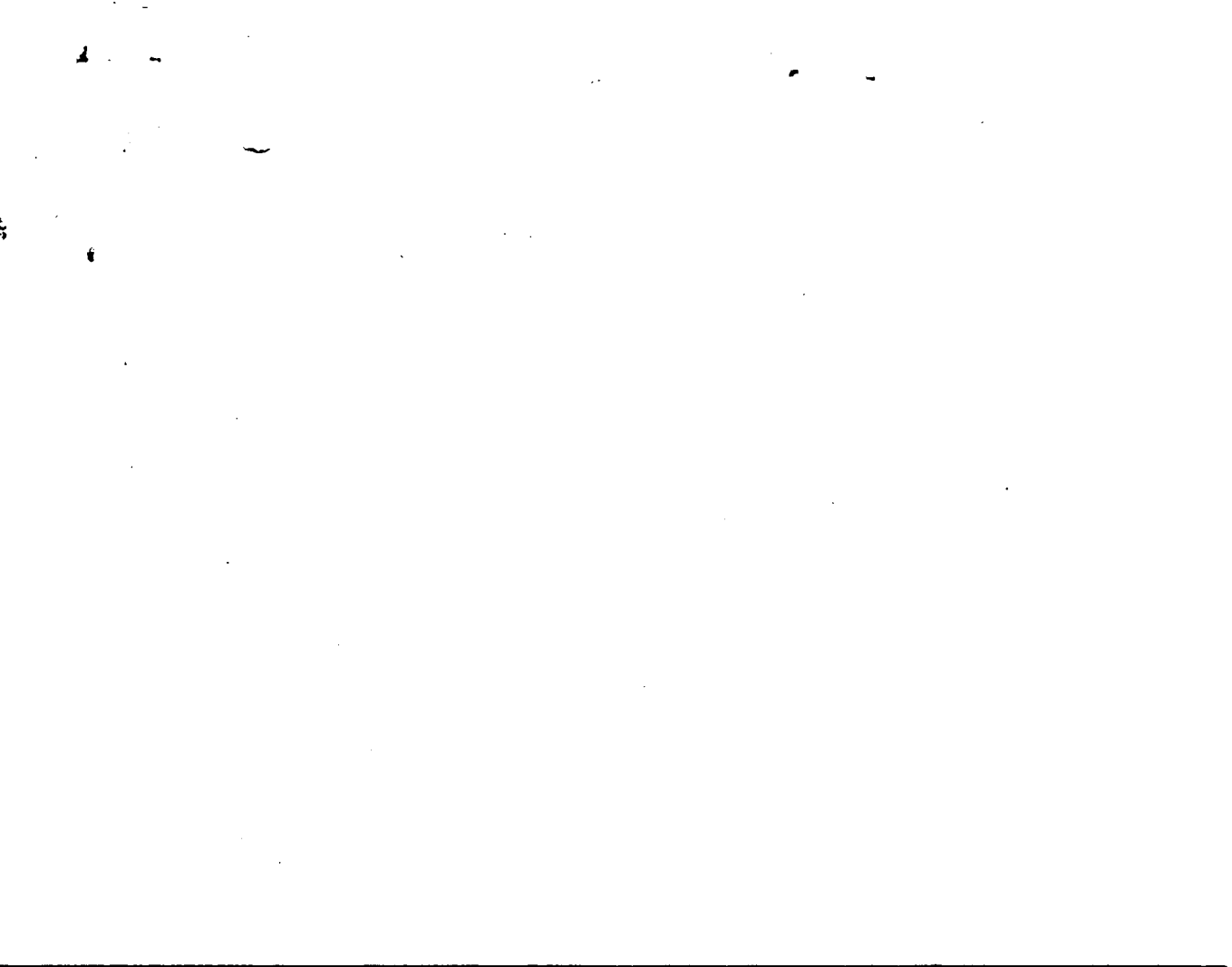
Address **Boise**

Filed **6/11/29** **W. Z. Rhodes**

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

mother died with Eclampsia.



RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66388

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2

Primary Registration District No. 11004
(No. St. Lukes Hospital)

Local Registrar's No. 165

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Fisk

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 29 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn
8. OCCUPATION OF DECEASED None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)

10. NAME OF FATHER Charles Fisk

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Edna Marie Richardson

13. BIRTHPLACE OF MOTHER (city or town) Jackson Wash.
(State or Country)

14. Informant Charles Fisk
(Address) Eagle Idaho R.D. #1

15. Filed 6-13-29 W.H. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH was as follows:
Premature (child not exp)

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. J. C. M. D. 5/30 1929 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial Morris Lee Amberg June 1929

20. Undertaker Address Summers & Trep Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

171732 D

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

819-206-003-652
PLACE OF BIRTH

County of Gannock
City of Lava Hot Springs

No. _____ St. _____

Municipal Sanitarium
(If born in hospital or institution give name.)

Registration District No. 84 State File No. 171788

Prima Registration District No. 2161 Local Registrar's No. 685

FULL NAME OF CHILD Stillbirth (Harper)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>May 6</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	---	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Tom Harper
Residence (Usual place of abode) Lava Hot Springs
If nonresident, give place and State _____
Color or race White Age at last Birthday 45 (Years)
Birthplace Adlington England
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Jessie Mary Webb
Residence (Usual place of abode) Lava Hot Springs
If nonresident, give place and State _____
Color or race White Age at last Birthday 32 (Years)
Birthplace Douglas Idaho
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive
Stillborn } at 11:00 A. M.
on the date above stated.

(Signature) C. A. Rich
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Lava Hot Springs Ida
Filed June 2 1929 Mr. G. B. Fitz
Registrar.

OFFICE OF THE ATTORNEY GENERAL

John, Registration District No. 2, Local Registrar's

DATE OF THE J.F.W.

(U) [REDACTED]

18	Date of birth	19	Place of birth	20	Place of birth	21	Place of birth	22	Place of birth	23	Place of birth	24	Place of birth	25	Place of birth	26	Place of birth	27	Place of birth	28	Place of birth	29	Place of birth	30	Place of birth	31	Place of birth	32	Place of birth	33	Place of birth	34	Place of birth	35	Place of birth	36	Place of birth	37	Place of birth	38	Place of birth	39	Place of birth	40	Place of birth	41	Place of birth	42	Place of birth	43	Place of birth	44	Place of birth	45	Place of birth	46	Place of birth	47	Place of birth	48	Place of birth	49	Place of birth	50	Place of birth	51	Place of birth	52	Place of birth	53	Place of birth	54	Place of birth	55	Place of birth	56	Place of birth	57	Place of birth	58	Place of birth	59	Place of birth	60	Place of birth	61	Place of birth	62	Place of birth	63	Place of birth	64	Place of birth	65	Place of birth	66	Place of birth	67	Place of birth	68	Place of birth	69	Place of birth	70	Place of birth	71	Place of birth	72	Place of birth	73	Place of birth	74	Place of birth	75	Place of birth	76	Place of birth	77	Place of birth	78	Place of birth	79	Place of birth	80	Place of birth	81	Place of birth	82	Place of birth	83	Place of birth	84	Place of birth	85	Place of birth	86	Place of birth	87	Place of birth	88	Place of birth	89	Place of birth	90	Place of birth	91	Place of birth	92	Place of birth	93	Place of birth	94	Place of birth	95	Place of birth	96	Place of birth	97	Place of birth	98	Place of birth	99	Place of birth	100	Place of birth
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What property rights was used to prevent Oppland's contribution?

...of child of this mother, including present birth

There was no other person

ALTON

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 08-11-2010 BY 60322
UCBAW/BJA

SECRET

• J. R. P. 9
1916-1917

--- (State to state land) ---

11. Incident Report Form

CONFIDENTIAL

~~SECRET~~

(1) to (4) of (1997) or (1998)

የጥቅም ጥሪ

• FIVE TO SEVEN DOLLARS TO STATION

SECRET

hardly recall that I attended the birth of this child, who was

in the late 1960s

(Zitat)

(Continued on next page)

[illegible]

MARGIN RESERVED FOR DULING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66820

County of Bannock

Registration District No. 84

City of Lava Hot Springs

Primary Registration District No. 2161

Local Registrar's No. 157

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stallworth

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 6, 1929

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Lava Hot Springs
(State or country) Idaho

10 NAME OF FATHER Tom Harper

11 BIRTHPLACE OF FATHER (city or town) Bedlington
(State or country) England

12 MAIDEN NAME OF MOTHER Jessie Mary Webb

13 BIRTHPLACE OF MOTHER (city or town) Downey
(State or country) Idaho

14 Informant C. A. Rich App. from Birth cert.
(Address) Lava Hot Springs

15 Filed June 7, 1929 Mrs. J. B. Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from On May 6, 1929, to May 6, 1929, that I last saw her Dead May 6, 1929, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Stallworth
7 1/2 mo. Gestation
Cause Unknown
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) None Known
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? None
(Signed) C. A. Rich J. D.
5-6, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
19

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

414-208-2803-331-
PLACE OF BIRTH RECEIVED JUL 3 1929
County of Pannock
City of Lava Hot Springs

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

171790

No. _____ St. _____
Municipal Sanitarium Registration District No. 84 State File No. _____
(If born in hospital or institution
give name.) Prim. Registration District No. 2161 Local Registrar's No. 683

FULL NAME OF CHILD Jenny Maughan (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 4</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 10 (a) Born alive and now living 9
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME John Raymond Maughan
Residence (Usual place of abode) Lava Hot Springs
If nonresident, give place and State _____
Color or race White Age at last Birthday 44 (Years)
Birthplace Wooten Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Lera Clark
Residence (Usual place of abode) Lava Hot Springs
If nonresident, give place and State _____
Color or race White Age at last Birthday 49 (Years)
Birthplace Farmington Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 6:00 P. M.
on the date above stated.

(Signature) C. H. Rich
M.D.
(Physician or midwife)

Address Lava Hot Springs

Filed June 7 1929 Mr. G. J. Fitz
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

THIS IS A COPY OF THE ORIGINAL RECORD
 IN THE CASE OF THE CHILD
 BORN AT THE
 HOSPITAL ON THE
 10th of May 1914

*Where there was an attending physician or midwife, then the fact of attendance, etc., should be stated. A stillborn child is one that never breathes nor shows other evidence of life after birth.

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Registration District No. 84 State of New York
 Local Registration No. 816

Full name of child: [illegible]
 Sex: [illegible]
 Date of birth: [illegible]
 Place of birth: [illegible]

Parents: [illegible]
 Mother: [illegible]
 Father: [illegible]

Occupation: [illegible]
 Education: [illegible]

Number of children of this mother, including present birth: [illegible]
 Born alive but now dead: [illegible]

Signature of attending physician or midwife: [illegible]
 Signature of registrar: [illegible]

Address: [illegible]
 Date: [illegible]

MARGIN RESERVED FOR DIVIDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

66821

State File No.

Local Registrar's No. 156

PLACE OF DEATH

County of Bannock

Registration District No.

City of Lava Hot Spring

Primary Registration District No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jenny Maughan (Stillbirth)

(a) Residence, No. _____ St. 206

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 4, 1929

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. Stillbirth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lava Hot Spring
(State or country) Idaho

10 NAME OF FATHER John Raymond Maughan

11 BIRTHPLACE OF FATHER (city or town) Weston Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Lera Clark

13 BIRTHPLACE OF MOTHER (city or town) Hamington Utah
(State or country)

14 Informant C. A. Rich copy from birth certificate
(Address) Lava Hot Spring

15 Filed June 7, 1929 Mrs. G. G. Fife
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from on May 4, 1929, to 19,
that I last saw her alive on Stillbirth, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Unknown Stillbirth in 7th month gestation

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) None known

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted _____
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None
(Signed) C. A. Rich M. D.
May 6, 1929 (Address) Lava Hot Spring

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____ 19____

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock
City of Cleveland, Ida

No. 231-109003-249 St.

(If born in hospital or institution
give name.)

Registration District No. 23 State File No. S 171798

Prim. Registration District No. 2160 Local Registrar's No. 464

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins or other? <u>and</u>	Number in order of birth <u>yes</u>	Legitimate? <u>yes</u>	Date of birth <u>May 9</u> 19 <u>20</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Guy H. Stalker

Residence (Usual place of abode) Thatcher, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 34

Birthplace Thatcher, Ida (Years)

(City and State or Country)

Occupation School Teacher

MOTHER
FULL MAIDEN NAME Nellie Smith

Residence (Usual place of abode) Thatcher Ida

If nonresident, give place and State

Color or race White Age at last Birthday 22

Birthplace Cleveland, Ida (Years)

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4-45 A. M. on the date above stated.

(Signature) G. W. Staton

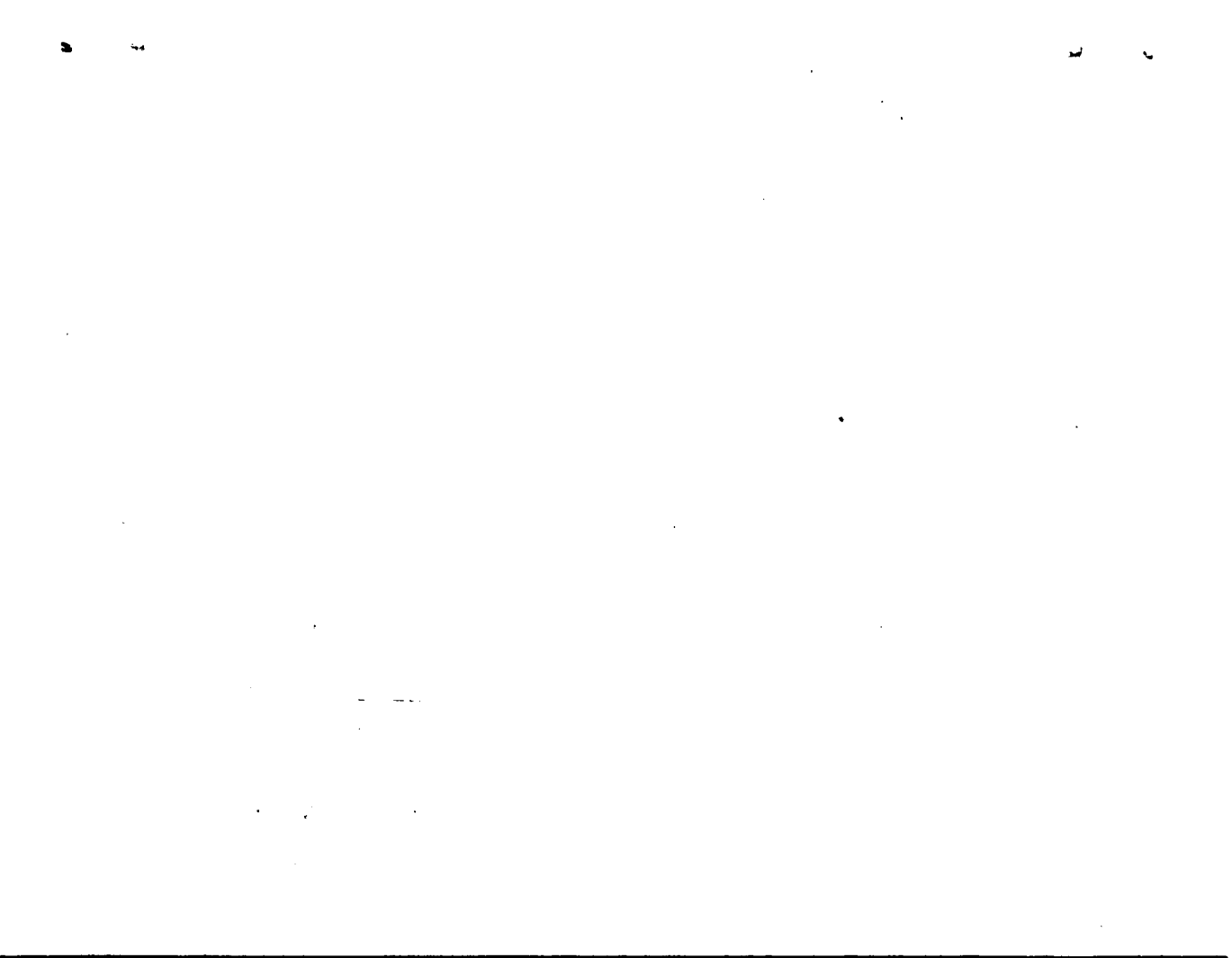
N. D.
(Physician or midwife)

Address Preston, Ida

Filed July 1-1920 Mary C. Coffin

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M. 1-19.

1.

RECEIVED JUL 13 1929

County of Bannock
City of Cleveland

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 83
Primary Registration District No. 2160
(No. _____ St.)Still BornSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 66410
Local Registrar's No. 111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word)

6. DATE OF BIRTH

May 9 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?— Yrs. — Mos. — ds. —

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business or establishment in which employed (or employer).

child

9. BIRTHPLACE

(State or Country) Cleveland, Ida10. NAME OF
FatherGuy H. Stalker11. BIRTHPLACE
OF FATHER(State or Country) Shateher, Ida12. MAIDEN NAME
OF MOTHERNellie Smith13. BIRTHPLACE
OF MOTHER(State or Country) Cleveland, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Guy H. Stalker
Cleveland

15.

Filed July 1 - 1929 Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1929
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 9 1929 to May 9 1929,that I last saw h. — alive on — 19 —,
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Died some days before birth.
Premature birth.(Duration) — yrs. — mos. — ds.Contributory (Secondary) Long distant journey by
train used auto(Duration) — yrs. — mos. — ds.(Signed) G. W. State M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place — In the —
of death — yrs. — mos. — days. State — yrs. — mos. — ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Cleveland, Ida

DATE OF BURIAL

May 10 1929

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

613-215-103-365
PLACE OF BIRTH
RECEIVED JUL 13 1929
County of Bannock
City of Cleveland, Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 171800

No. St.

Registration District No. 89 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2160 Local Registrar's No. 466-

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 15</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 12 (a) Born alive and now living 8

Born alive but now dead 3 Stillborn 1

FATHER
FULL NAME Chester Walton
Residence (Usual place of abode) Cleveland, Ida
If nonresident, give place and State
Color or race White Age at last Birthday 47 (Years)
Birthplace Cleveland, Ida
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Olive Covert
Residence (Usual place of abode) Cleveland, Ida
If nonresident, give place and State
Color or race White Age at last Birthday 4 (Years)
Birthplace Butlerville, Ut
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 1:45 A. M.
on the date above stated. { Stillborn

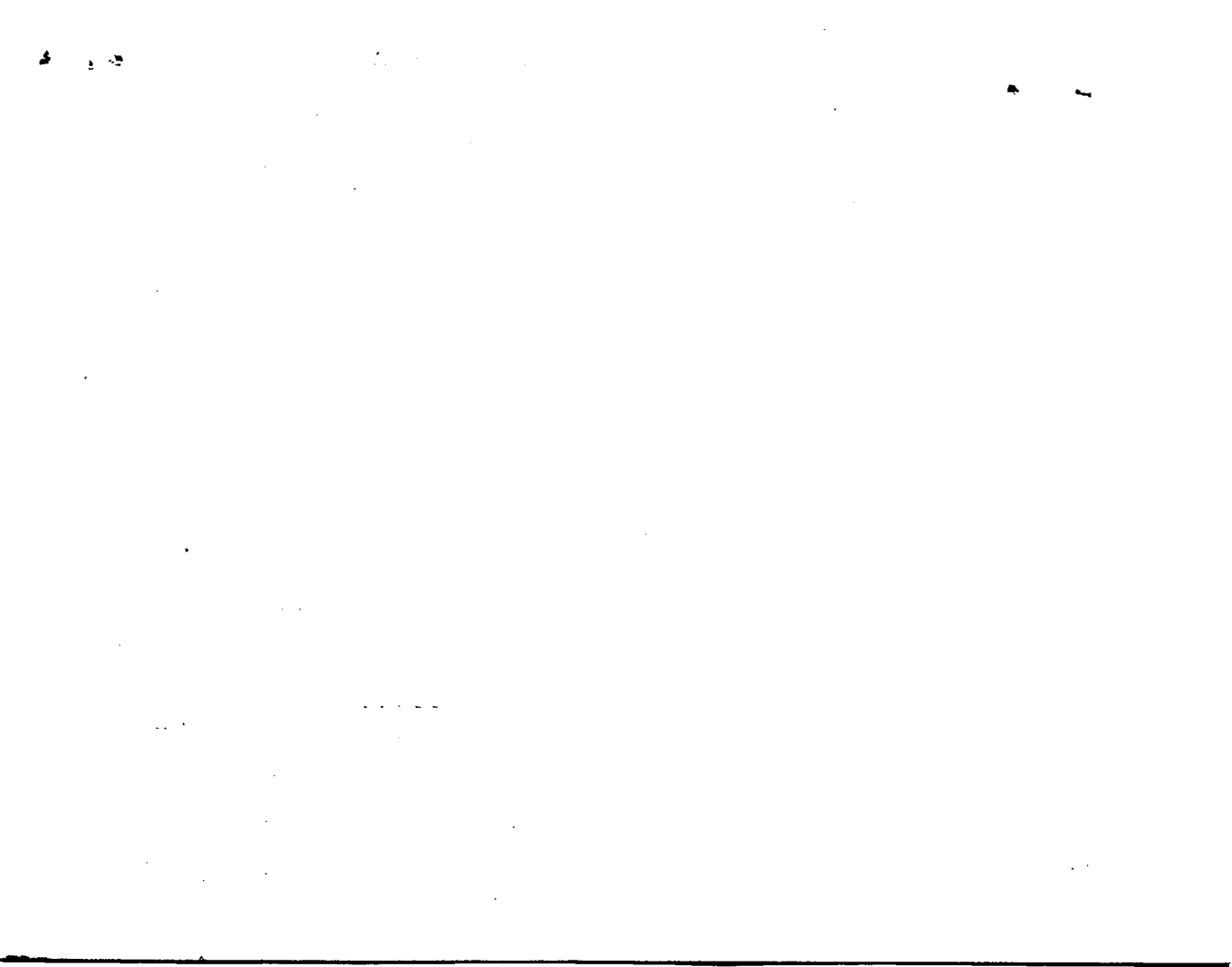
(Signature) E. W. States

M. D.
(Physician or midwife)

Address Preston, Ida

Filed July 1-1929 Marion C. Coffin
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED JUL 13 1929** CERTIFICATE OF DEATHCounty of **Bannock** Registration District No. **83**
City of **Cleveland, Ida** Primary Registration District No. **2100**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. **66409**
Local Registrar's No. **119**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

Female White single
(Write the word)

6. DATE OF BIRTH

May 15 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **Cleveland, Ida**

10. NAME OF Father

Chester Walton

11. BIRTHPLACE OF FATHER

(State or Country) **Cleveland, Ida**

12. MAIDEN NAME OF MOTHER

Olive Covert

13. BIRTHPLACE OF MOTHER

(State or Country) **Butterville, Ut**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chester Walton
(Address) **Cleveland, Ida**

15.

Filed **July 1 - 1929** **Nary C. Coffey**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1929
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **May 15 1929** to **May 15 1929**, that I last saw him **live on dead** 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Dead several days before birth -
An Exencephalic Child -

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory **Premature by one**
(Secondary) **month**

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **G. W. States** M. D.**5/16/1929** (Address) **Butterville, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Cleveland, Ida

DATE OF BURIAL

May 16 1929

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED **RECEIVED** JUL 5 1929
County of **Ft. Hall Reservation** STATE OF IDAHO
Idaho. DEPARTMENT OF PUBLIC WELFARE
City of _____ BUREAU OF VITAL STATISTICS
No. **259222-006-315** St. _____
Ft. Hall Agency Hospital Registration District No. **121-R** State File No. **171901**
(If born in hospital or institution
give name.) Prim. Registration District No. **2194-R** Local Registrar's No. **185**

FULL NAME OF CHILD **Doris Edna Kniffin**

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female	Twin Triplet or other? _____	Number in order of birth _____	Legitimate? Yes	Date of birth May 22, 1929
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? -----

Number of child of this mother, including present birth **2** (a) Born alive and now living **I**
Born alive but now dead **0** Stillborn **I**

FATHER
FULL NAME **Julian Kniffin**
Residence (Usual place of abode) **Ft. Hall Reserv.**
If nonresident, give place and State **Mo hawk Ind. 3/8**
Color or race _____ Age at last Birthday **34** (Years)
Birthplace **Pocatello, Idaho.**
(City and State or Country)
Occupation **Farming**

MOTHER
FULL MAIDEN NAME **Annie Laura LaVatta**
Residence (Usual place of abode) **Same**
If nonresident, give place and State **Shoshone Ind. 3/8**
Color or race _____ Age at last Birthday **24** (Years)
Birthplace **Mo. Cannon, Idaho**
(City and State or Country)
Occupation **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **born alive** Stillborn { at **10 P.** M.
on the date above stated.

(Signature) **Henry R. Wheeler**

(Physician or midwife)

Address **Ft. Hall, Idaho.**

Filed **June 16 29** **M. Walter E. Stail**
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1.1.1

1.1.2

1.1.3

1.1.4

1.1.5

1.1.6

1.1.7

1.1.8

1.1.9

1.1.10

1.1.11

1.1.12

1.1.13

1.1.14

1.1.15

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 66851

PLACE OF DEATH
County of Ft. Hall Reservation **CERTIFICATE OF DEATH**
Idaho.

City of
Registration District No. 121-R
Primary Registration District No. 2194-R

Local Registrar's No. 123(No. Ft. Hall Agency Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorris Edna Kniffin.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female COLOR OR RACE Shoshone
Ind. 7/16 5. Single, Married, Widowed,
Single or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6. DATE OF BIRTH (month, day and year) May 22, 1929

7. AGE Years Months Days If LESS than 1 day,
0 0 0 0 hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work None(b) General nature of industry,
business, or establishment in
which employed (or employer) -----

(c) Name of employer -----

9. BIRTHPLACE (city or town) Ft. Hall Reservation
(State or country)10. NAME OF FATHER Julian Kniffin11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Pocatello, Idaho12. MAIDEN NAME OF MOTHER Annie L. LaVatta13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mc. Cammon, Idaho14. Informant Annie Kniffin.
(Address) Ft. Hall, Idaho.15. Filed July 22, 1929 Mc. Wata, E. D. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 22, 1929, to May 22, 1929that I last saw she was born dead. 10 P.and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:Stillborn at term, cause unknown(duration) yrs. mos. 0 ds.CONTRIBUTORY Immoderate exercise
(Secondary) of the mother before birth

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None
(Signed) Henry P. Wheeler, M. D._____, 19____ (Address) Ft. Hall, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Ft. Hall Reservation, May 23 192920. Undertaker Address
Mc. Han & Co. Pocatello, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-111007-255
PLACE OF BIRTH
RECEIVED JUL 5 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
CERTIFICATE OF BIRTH
County of Blaine
City of Hailey
No. _____ St. _____
Registration District No. 57 State File No. 171934
Prim. Registration District No. 2022 Local Registrar's No. 41
(If born in hospital or institution give name.)

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>6</u> <u>11</u> <u>1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead none Stillborn yes - 1

FATHER	MOTHER
FULL NAME <u>Devey V. Burke</u>	FULL MAIDEN NAME <u>Burk Marie Seve</u>
Residence (Usual place of abode) <u>Hailey</u>	Residence (Usual place of abode) <u>Hailey</u>
If nonresident, give place and State <u>Ida</u>	If nonresident, give place and State <u>Ida</u>
Color or race <u>white</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Colorado</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn } at 59 M.
on the date above stated.

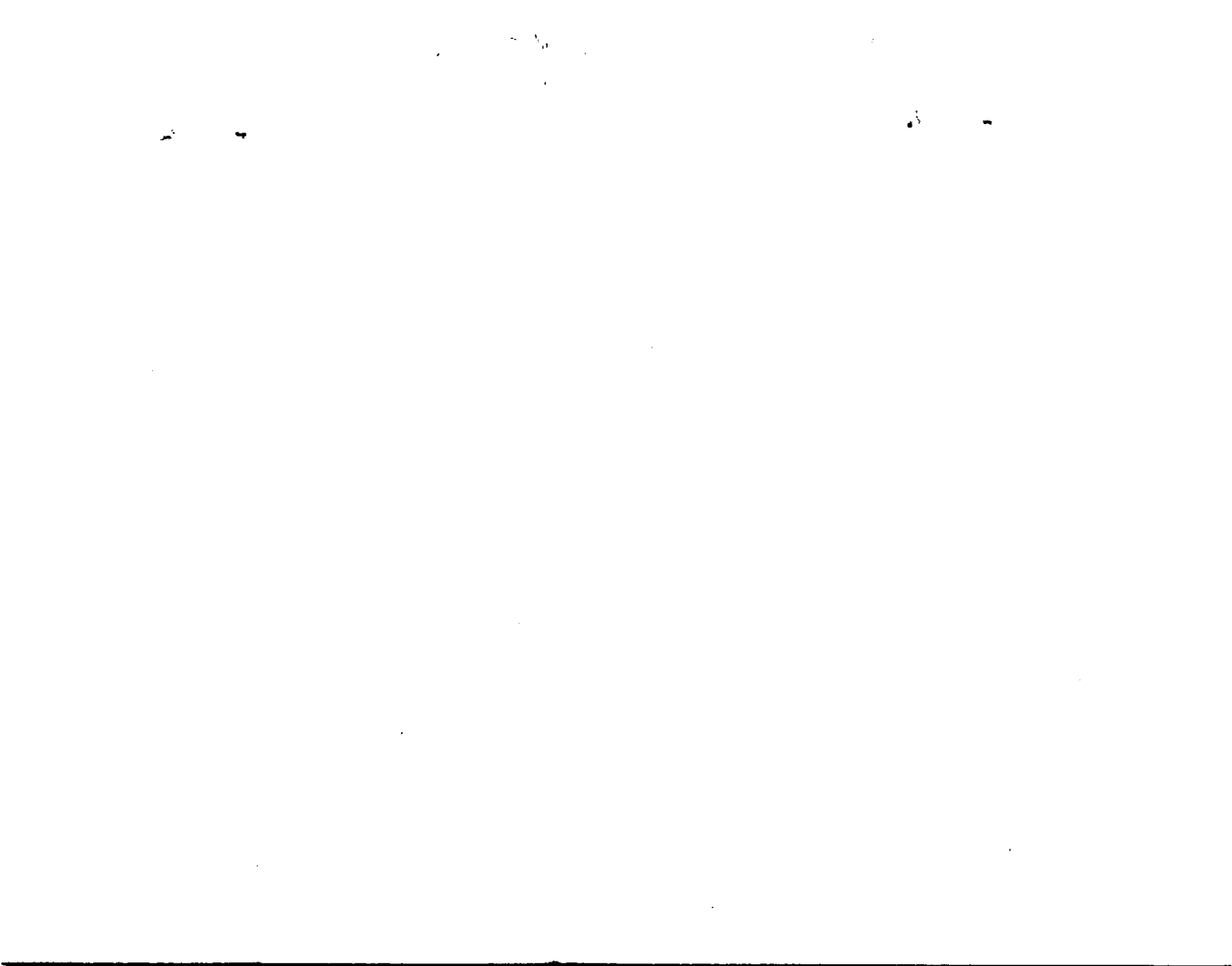
(Signature) Robert H. Wright-M.D.

(Physician or midwife)

Address Hailey, Ida

Filed 6-30 1929 Robert H. Wright
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

66448

State File No.

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 54
Primary Registration District No. 2022

Local Registrar's No. 24

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Burks

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11, 1929

7. AGE Still born born dead
Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hailey
(State or country)10. NAME OF FATHER Dewey Burks11. BIRTHPLACE OF FATHER (city or town) Denver Colo.
(State or Country)12. MAIDEN NAME OF MOTHER Beth Severe13. BIRTHPLACE OF MOTHER (city or town) Fairfield-Ida
(State or Country)

14. Informant Dewey Burks
(Address) Hailey - Ida.

15. Filed 6-30, 1929 W. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11, 1929, to June 11, 1929
that I last saw him alive on June 11, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Robert H. Wright M. D.

(Signed) 6-12, 1929 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hailey Idaho Date of Burial June 11 1929

20. Undertaker E 244 Address Hailey & Amos

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth returned.

384-15-009-343
PLACE OF BIRTH

County of Bonanza
City of Sandpoint
No. _____ St.

RECEIVED JUL 6 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
171968

(If born in hospital or institution
give name.)

Registration District No. 78 State File No. _____
Prim. Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Immanuel
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>Yes</u>	Date of birth <u>6 15 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 8
Born alive but now dead _____ Stillborn _____

FATHER		MOTHER	
FULL NAME <u>E. J. Thurlow</u>	FULL MAIDEN NAME <u>Maggie Tucker</u>		
Residence (Usual place of abode) <u>Sandpoint</u>	Residence (Usual place of abode) <u>Sandpoint</u>		
If nonresident, give place and State _____	If nonresident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>47</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>40</u> (Years)		
Birthplace <u>Mich</u> (City and State or Country)	Birthplace <u>Mich</u> (City and State or Country)		
Occupation <u>Laborer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 9 P. M.
on the date above stated.

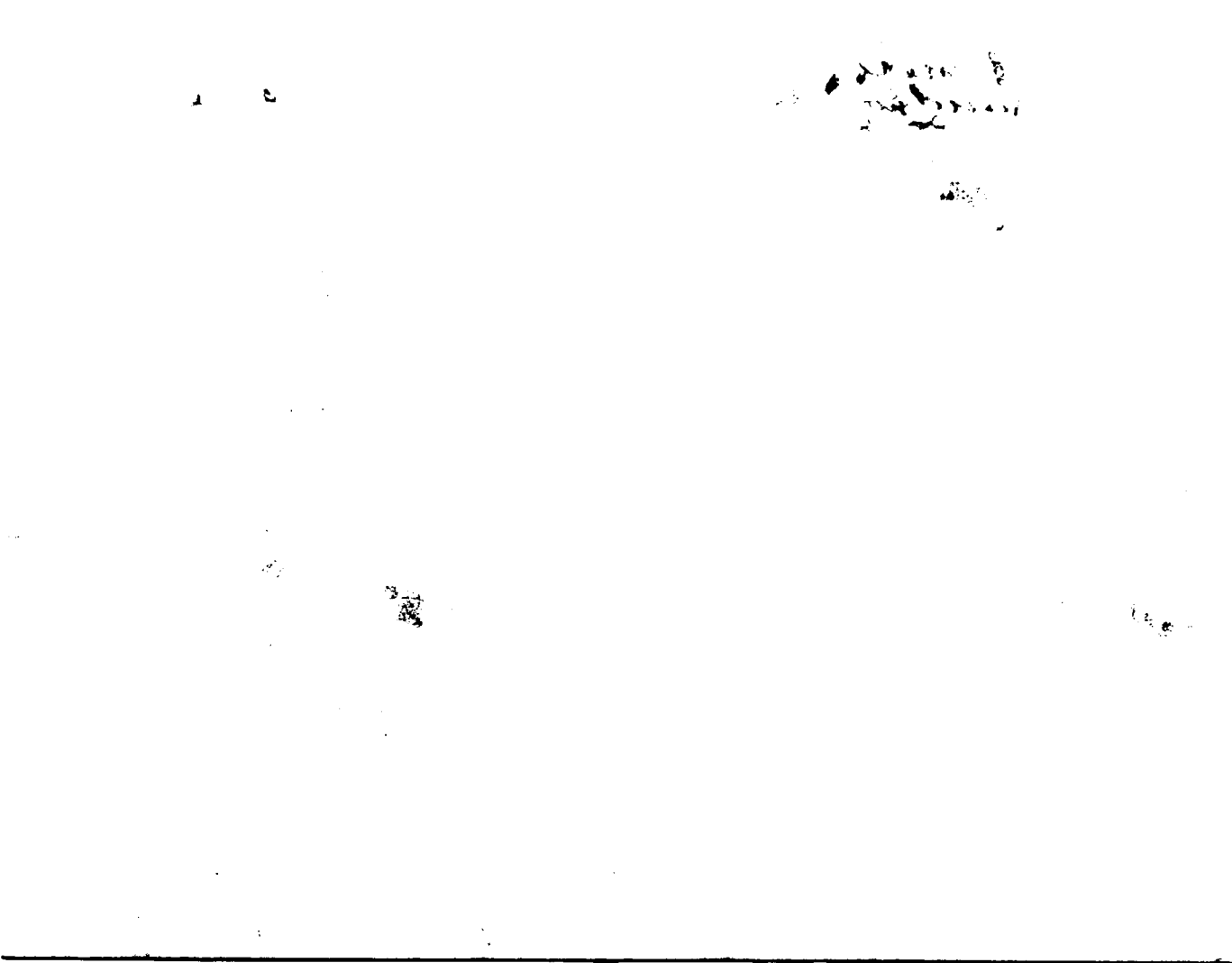
(Signature) B. E. Alcorn

(Physician or midwife)

Address Sandpoint, Ida

Filed July 3 1929
Viola Allen
Deputy Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66465

PLACE OF DEATH

County of BonnerCity of SandpointRegistration District No. 78Primary Registration District No. 2155

Local Registrar's No. _____

(No. 906 Ella Avenue)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Thurlow(a) Residence. No. 906 Ella Ave. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) June 15, 19297. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho10. NAME OF FATHER
Earl Thurlow11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Michigan12. MAIDEN NAME OF MOTHER
Margaret Tucker13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Michigan14. Informant Earl Thurlow
(Address) Sandpoint15. Filed June 17, 1929 Viola Allen
Idaho Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH was as follows:

Stillborn, slight abdominal
Evidently dead a short time
before being taken out in
bag at 14 1/2 hrs.CONTRIBUTORY 10 months gestation
(Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) GE Alcorn, M.D.June 17, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Pinecrest CemeteryDate of Burial
June 17, 192920. Undertaker
Moon's Mortuary, Sandpoint, Idaho

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

962-205-010-942
PLACE OF BIRTH RECEIVED JUN 19 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Bonneville
CITY OF Idaho Falls
No. _____ St. _____
L.W.S. Hospital Registration District No. 73 State File No. S 171993
(If born in hospital or institution give name.) Prim. Registration District No. 2195 Local Registrar's No. 203
FULL NAME OF CHILD Opal June Robbins 8; 1929
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Female Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth May 3 1929
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth 7 (a) Born alive and now living 6
Born alive but now dead _____ Stillborn 1
FATHER FULL NAME Joseph Hyrum Robbins MOTHER FULL MAIDEN NAME Annie Viola Russell
Residence (Usual place of abode) Route 3 Residence (Usual place of abode) Route 4 S.
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 52 Color or race White Age at last Birthday 39
Birthplace Bonham, Utah (City and State or Country) Birthplace Carleton, Utah (City and State or Country)
Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

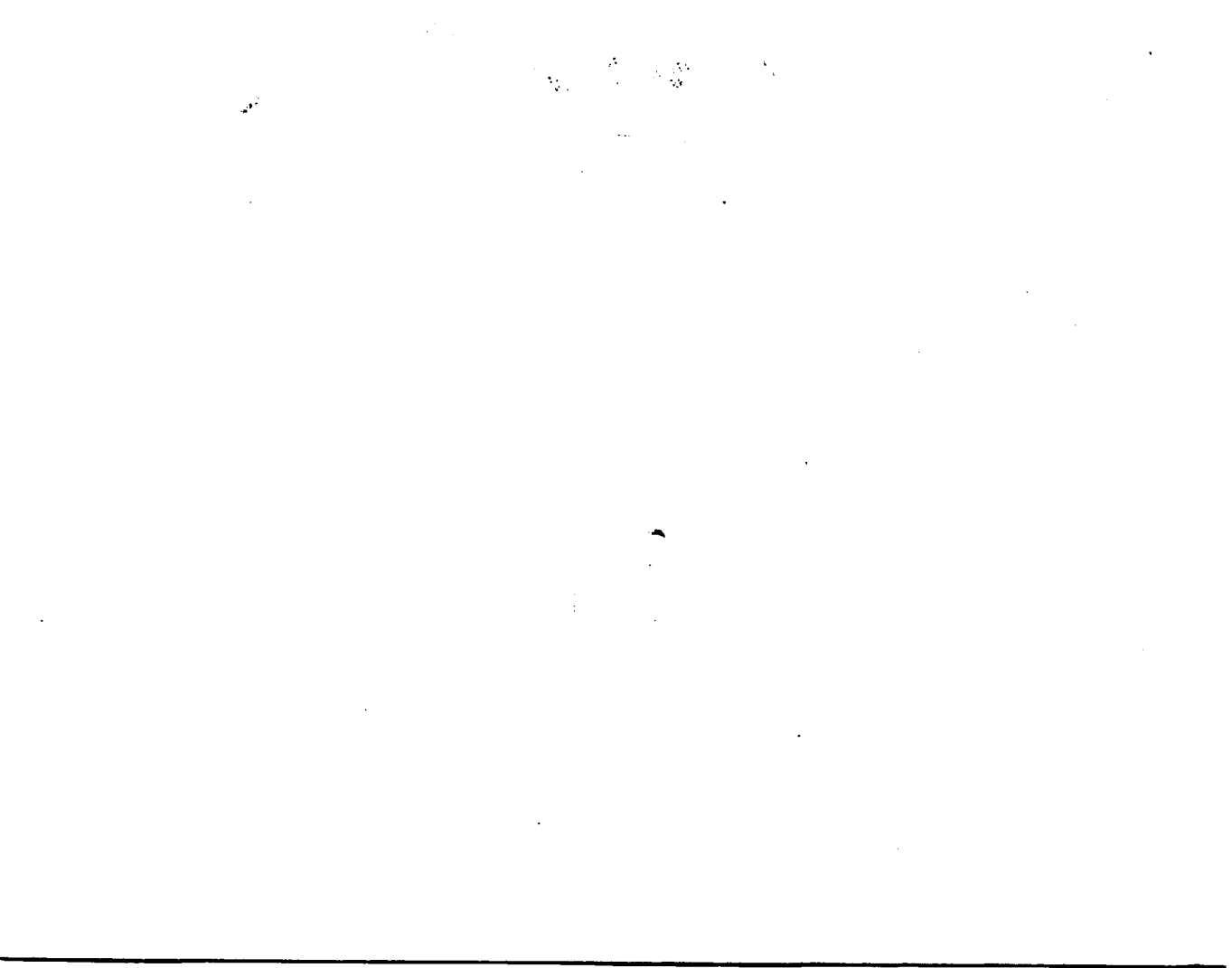
I hereby certify that I attended the birth of this child, who was Born alive at 8:20 P. M.
on the date above stated. Stillborn

(Signature)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed May 9 1929 Idaho Falls
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

296-204,010 393
PLACE OF BIRTH

County of Bannock
City of Ammon, Idaho
No. _____ St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 73 State File No. 172004

Prim. Registration District No. 14-D Local Registrar's No. 214

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 4</u> (Month) (Day) (Year) <u>1929</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 10 (a) Born alive and now living 7

Born alive but now dead 3 Stillborn _____

FATHER
FULL NAME William M. Brown
Residence (Usual place of abode) Ammon, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 46
(Years)
Birthplace Russia
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Elizabeth Lilaf
Residence (Usual place of abode) Ammon, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 40
(Years)
Birthplace Russia
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 5 P. M.
on the date above stated.

(Signature)

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Idaho Falls, Idaho

Filed May 30 1929 W. J. [Signature]
Registrar.

10
D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

249414.010-693
PLACE OF BIRTH

County of Benewah
City of Lana
No. St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 23 State File No. 172008

Prim. Registration District No. 214-6 Local Registrar's No. 219

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>Yes</u>	Date of birth <u>May 14</u> (Month) (Day)	19 <u>29</u> (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol Sol 10%

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME <u>James Albert Smith</u>	FULL MAIDEN NAME <u>Marion Nelson</u>
Residence (Usual place of abode) <u>Lana, Idaho</u>	Residence (Usual place of abode) <u>Lana, Idaho</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>white</u> Age at last Birthday <u>31</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>26</u> (Years)
Birthplace <u>Missouri</u> (City and State or Country)	Birthplace <u>Missouri</u> (City and State or Country)
Occupation <u>Agent</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12:10 A. M.
on the date above stated.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls, Idaho

Filed May 2 1929 [Signature]
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

10
D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

814-108-010-619
PLACE OF BIRTH

County of Bonneville
City of Idaho Falls

No. _____ St.

Spencer
(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 73 State File No. 172033

Prim. Registration District No. 2120 Local Registrar's No. 266

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> Number in order of birth	Legitimate? <u>Y</u>	Date of birth <u>June 8</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Henry Walter Vaderfi
Residence (Usual place of abode) Idaho Falls
If nonresident, give place and State P. F. D #1
Color or race white Age at last Birthday 47 (Years)
Birthplace Providence Utah
(City and State or Country)
Occupation raucher

MOTHER
FULL MAIDEN NAME Ruth Ward
Residence (Usual place of abode) _____
If nonresident, give place and State _____
Color or race white Age at last Birthday 37 (Years)
Birthplace Idaho
(City and State or Country)
Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2³⁰ P. M. on the date above stated.

(Signature) H. S. Jones M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Idaho Falls, Ida

Filed 6/29 1929 W. J. W. W.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bannock

City of Idaho Falls

No. 415-129010-14 St.

L. D. S. Hospital
(If born in hospital or institution
give name.)

Registration District No. 73 State, File No. 172062

Prim. Registration District No. 21470 Local Registrar's No. 244

FULL NAME OF CHILD S. K. B. B. B.

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>May 29 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead none Stillborn 1

FATHER

FULL NAME Theodore R. David

Residence (Usual place of abode) Idaho Falls, Idaho R4

If nonresident, give place and State

Color or race White Age at last Birthday 27
(Years)

Birthplace Lamar, Iowa
(City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Alice Caroline Adams

Residence (Usual place of abode) Idaho Falls, Idaho R4

If nonresident, give place and State

Color or race White Age at last Birthday 26
(Years)

Birthplace Roberts, Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

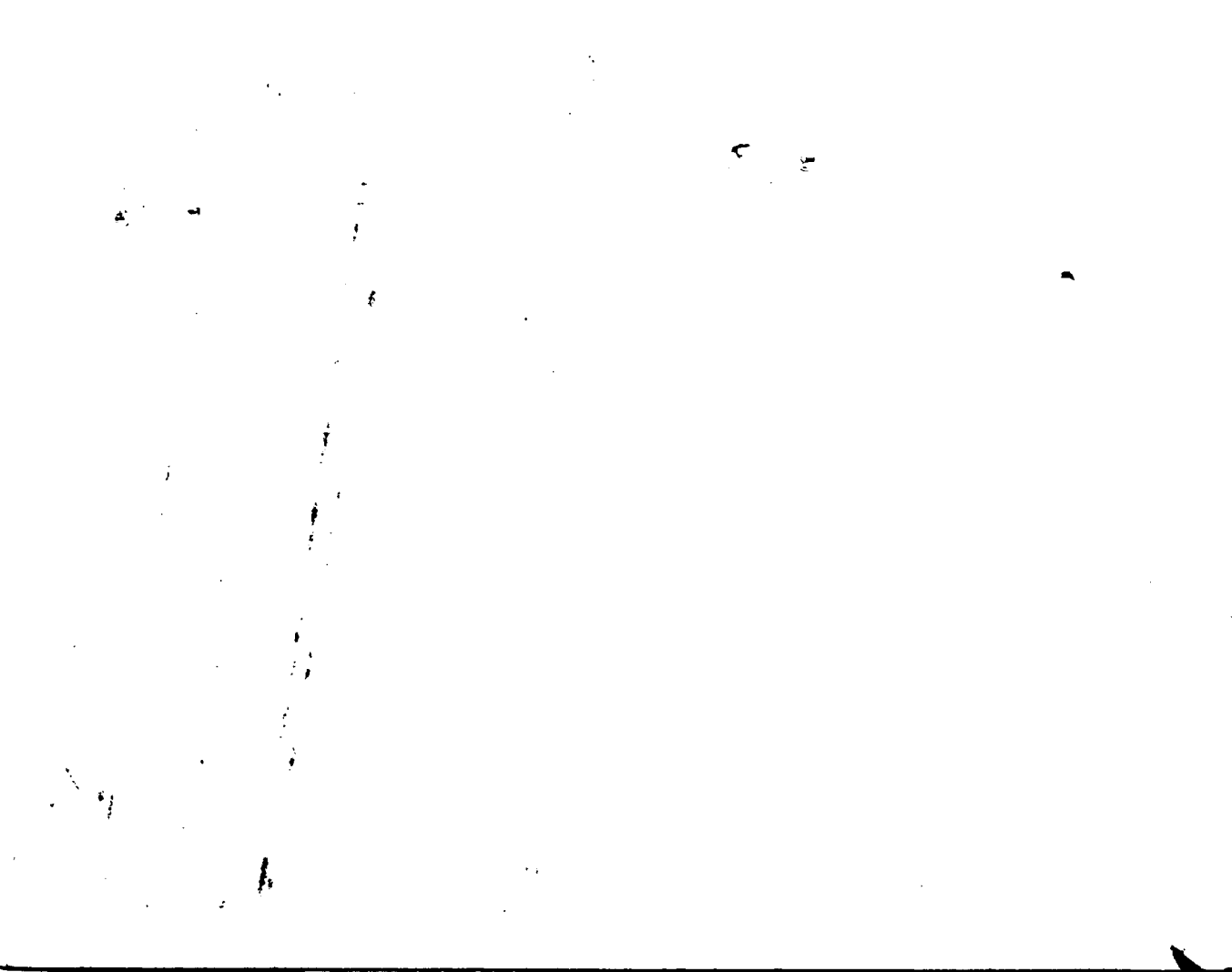
I hereby certify that I attended the birth of this child, who was Born alive at 925 P. M.
on the date above stated.

(Signature) [Signature]
(Physician midwife)

Address Idaho Falls, Idaho

Filed June 7 1929 Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67540

PLACE OF DEATH

County of Bonerville **CERTIFICATE OF DEATH**City of Idaho Falls Registration District No. 73Primary Registration District No. 214-0Local Registrar's No. 166(No. H. N. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant David(a) Residence. No. Idaho Falls St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)malewhiteSingle5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.0000

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c). Name of employer

None.9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant
(Address)

15. Filed

Sept 12, 1927W. J. Mainland

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

May 29 29

17. I HEREBY CERTIFY, That I attended deceased from

May 29, 1927, to May 29, 1927that I last saw him alive on May 29, 1927and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Still Born - Hemorrhage
Recent
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of May 29, 1927Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Mainland, M. D.May 29, 1927 (Address) Idaho Falls, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Falls, Idaho May 29, 1927

20. Undertaker

Address

J. D. M. Han Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

205-121-016-638

PLACE OF

RECEIVED JUN 17 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

172156

County of

City of

No. St.

(If born in hospital or institution
give name.)

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 21</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 2 g/o

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER
FULL NAME Ray A. Sweet
Residence (Usual place of abode) Wells
If nonresident, give place and State
Color or race white Age at last Birthday 25 (Years)
Birthplace Idaho
City and State or Country
Occupation Laborer

MOTHER
FULL MAIDEN NAME Minnie G. Flynn
Residence (Usual place of abode) Wells
If nonresident, give place and State
Color or race white Age at last Birthday 23 (Years)
Birthplace Idaho
City and State or Country
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Boys alive at 9:15 A.M.
on the date above stated.

(Signature) Hugh E. Dean
(Physician or midwife)

Address Burley

Filed 15 1929 H. C. Cutler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

dwp 08 SB 1929-173039

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 1-7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66547

PLACE OF DEATH,
County of Cassia
City of Hecla

Registration District No.
Primary Registration District No.

Local Registrar's No.

(No.)
If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Sweet

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 19-29
7. AGE Still Born Years Months Days LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hecla Ida.
10. NAME OF FATHER Roy Sweet
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston Ida.
12. MAIDEN NAME OF MOTHER Marjorie Flynn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hecla Ida.
14. Informant Geo. Flynn
(Address) Hecla Ida.
15. Filed 6-10-29 1929 W. E. Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 19, 1929
that I last saw him alive on May 19, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Intoxication Acrophobia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Chlorine
(Signed) W. E. Johnson, M. D.
May 28, 1929 (Address) Burley Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hecla Ida. Date of Burial May 21 1929
20. Undertaker W. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

343-206-016-146
PLACED IN FILE
RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

172198

County of
City of
No. St.

Registration District No. State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 6</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate 20/0

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn 1

FATHER
FULL NAME Ralph Bullock
Residence (Usual place of abode) Burley
If nonresident, give place and State
Color or race white Age at last Birthday 24 (Years)
Birthplace Wash.
(City and State or Country)
Occupation clerk

MOTHER
FULL MAIDEN NAME Eila Jeffers
Residence (Usual place of abode) Burley
If nonresident, give place and State
Color or race white Age at last Birthday 20 (Years)
Birthplace Idaho
(City and State or Country)
Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:15 A. M.
on the date above stated.

(Signature) Dr. E. E. Dean

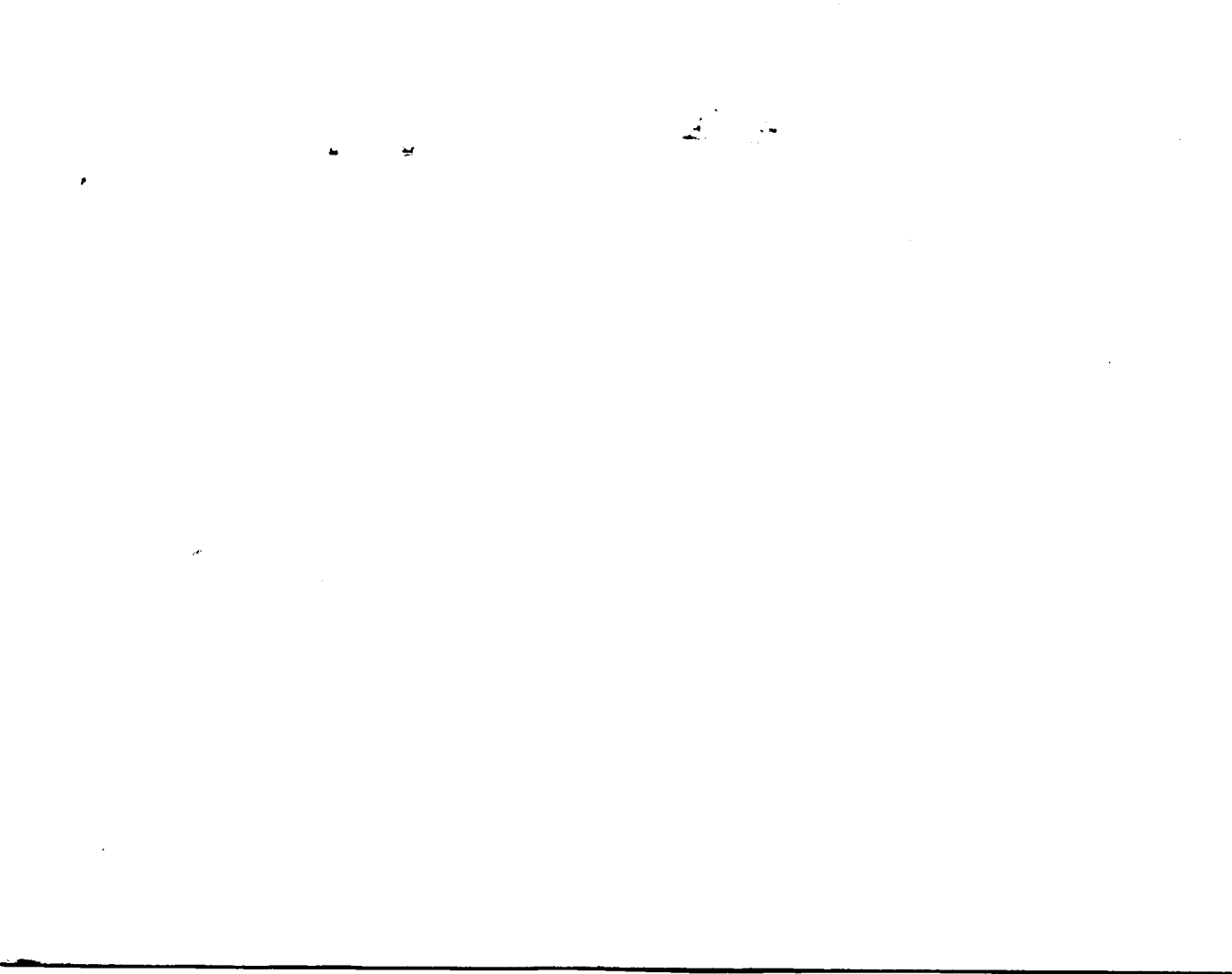
(Physician or midwife)

Address Burley

Filed 11 - 19 29 Dr. E. E. Dean

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66538

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Sullock

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6 / 1929

7. AGE Still Born Years Months Days LESS than 1 day
min. hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Burley Ida
(State or country)10. NAME OF FATHER Ralph Sullock11. BIRTHPLACE OF FATHER (city or town) Washington
(State or Country)12. MAIDEN NAME OF MOTHER Eila Haffner13. BIRTHPLACE OF MOTHER (city or town) Burley Ida
(State or Country)14. Informant Baby Sullock
(Address) Burley Ida15. Filed 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Burley, 1929, to June 6, 1929

that I last saw her alive on June 6, 1929

and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Infantile Tetanic Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Wm. E. Johnson, M. D.

June 10, 1929 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Date of Burial

Burley Ida June 6 1929

20. Undertaker W. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

172198 +

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer,**" etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile,**" etc.), "**Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness,**" etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull**, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

219-126-224 266
PLACE OF BIRTH
County of Go RECEIVED JUL 3 1927
City of Hagerman
No. St.
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
172266
Registration District No. 21 State File No.
Prim. Registration District No. Local Registrar's No.
FULL NAME OF CHILD Robert Lee Bardsley
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 26</u> 19 <u>27</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol
Number of child of this mother, including present birth 6 (a) Born alive and now living 4
Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME <u>Amos Bardsley</u>	FULL MAIDEN NAME <u>Isis Bowers</u>
Residence (Usual place of abode) <u>Hagerman</u>	Residence (Usual place of abode) <u>Hagerman</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday <u>57</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>46</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8 A. M.
on the date above stated.

(Signature) R. H. Greene
Physician
(Physician or midwife)

Address Hagerman
Filed May 30 1927 R. H. Greene
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-19-2010 BY 60322 UCBAW/STP/STP

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

PLACE OF BIRTH
COUNTY OF
CITY OF

Registration District No. _____ State Life No. _____
Birth Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____
It is affirmed and true the above is name of child

Sex of Child _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Month _____ Year _____

What prophylactic was used to prevent *Optalmia Neonatorum*? _____
Number of child of this mother, including present birth _____
How child was born _____

FATHER'S NAME _____
MOTHER'S NAME _____
Place of Birth _____
Date of Birth _____

Place of Birth _____
Date of Birth _____
Color of hair _____
Color of eyes _____

Place of Birth _____
Date of Birth _____
Color of hair _____
Color of eyes _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
Where there was no attending physician or midwife, then the father, householder, or neighbor, should make this return. If stillborn child is one that neither possesses nor shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was _____
(Signature) _____
on the date above stated.

Address _____
Filed _____
1897

MARGIN RESERVED FOR BINDING

5000126

172266

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66578

1. PLACE RECEIVED JUL 3 1929
Registration District No. 21
County of _____
Primary Registration District No. _____
City of _____ (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Robert Lee Bardsley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
6. DATE OF BIRTH May 26 1929
7. AGE Still born
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Hagerman
(State or Country)

10. NAME OF FATHER Armin Bardsley

11. BIRTHPLACE OF FATHER Ill
(State or Country)

12. MAIDEN NAME OF MOTHER Elsie Bowers

13. BIRTHPLACE OF MOTHER Ill
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Armin Bardsley
(Address) Hagerman

15. Filed May 27 1929 R.H. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to May 26 1929
that I last saw him alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Cord presentation at birth
Circulation cut off -
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) R.H. Greene M.D.
19 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hagerman DATE OF BURIAL May 27 1929
20. UNDERTAKER none ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

255-217-024-955
PLACE OF BIRTH
County of Idaho
City of Nagerman
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S172268**

Registration District No. 21 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Mary Kennedy

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>March 17</u> (Month) (Day) (Year) <u>1929</u>
----------------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth. 4 (a) Born alive and now living 3

Born alive but now dead. Stillborn one

FATHER
FULL NAME Robert L Kennedy
Residence (Usual place of abode) Nagerman
If nonresident, give place and State.
Color or race White Age at last Birthday 47 (Years)
Birthplace New
(City and State or Country)
Occupation Farming

MOTHER
FULL MAIDEN NAME Nellie J Kennedy
Residence (Usual place of abode) Nagerman
If nonresident, give place and State.
Color or race White Age at last Birthday 34 (Years)
Birthplace Colo
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at Still born 5:30 A.M.
on the date above stated.

(Signature) R. H. Greene

Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Nagerman

Filed Mar 18 19 29 R. H. Greene

Registrar.

John's dream is what we call the "inner voice."

* Where there was no standing of the father, or midwife, then the father, mother, etc., should make this return. A child born alive is one that neither mother nor father offer evidence of its birth.

(071542)

I hereby certify that I attended the birth of this child, who was

CONTINUANCE OF ATTENDING PHYSICIAN OR MIDWIFE.

notations

(City and State or Country)

(1) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)

1940

And of that I believe

DATE RECORDED BY: [illegible]

(Subject to some minor amendments)

JUN 27 1964

ИЗДАНИЕ

Let's see if you will do it.

(b) _____, child of this mother, including present birth _____ born alive and now living

that prophylactic use is needed to prevent Ophthalmia Neonatorum.

1941

(Slovak)

and

FILED IN THE OFFICE OF THE

17-00000-1 (17-00000-1)

Print Registration District No. _____ Local Registrar's No. _____

11. It appears, however, that the word "Belligerent" (as source of relief)

18-55200-101

to visit

Copyright of

BUREAU OF VITAL STATISTICS
DEPARTMENT OF HEALTH AND WELFARE

SECRET

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66589
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Nagerman
Registration District No. 21
Primary Registration District No.
(No. St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Mary Kennedy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
6. DATE OF BIRTH Mar 17 1919
7. AGE Still born
8. OCCUPATION
9. BIRTHPLACE Nagerman
10. NAME OF FATHER Robert L Kennedy
11. BIRTHPLACE OF FATHER Nev
12. MAIDEN NAME OF MOTHER Nellie
13. BIRTHPLACE OF MOTHER Colo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. G. Kennedy
(Address) 1919
15. Filed Mar 18 1919
Local Registrar R. N. Greene

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 17 1919
17. I HEREBY CERTIFY, That I attended deceased from arrival soon after birth that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Still born
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) R. N. Greene M. D.
(Address) Nagerman

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

359-103-27-212
PLACE OF BIRTH
RECEIVED JUL 12 1929
County of Jerome
City of Jerome

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 172319

No. St. Valentine Hoft St.
(If born in hospital or institution give name.)

Registration District No. 18 State File No. 18

Prim. Registration District No. 18 Local Registrar's No. 18

FULL NAME OF CHILD Baby Stratton Leonard Le Roy
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin <u>1st</u> and <u>1st</u> Number in order of birth <u>1st</u>	Legitimacy <u>yes</u>	Date of birth <u>June 3</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead No Stillborn yes

FATHER
FULL NAME Henry L. Stratton
Residence (Usual place of abode) Jerome, Idaho

If nonresident, give place and State None

Color or race W Age at last Birthday 20 (Years)

Birthplace Idaho, Castleford
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Emma Baker
Residence (Usual place of abode) Jerome, Idaho

If nonresident, give place and State None

Color or race W Age at last Birthday 19 (Years)

Birthplace Utah
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1:45 P. M. on the date above stated.

(Signature) C. F. Zeller

(Physician or midwife)

Address Jerome, Idaho

Filed 6/27 1929 Chas. F. Zeller
J.M.C. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

JUN 16 1966

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 12 1929

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66603

1. PLACE OF DEATH.

Registration District No. 18

County of Jerome

Primary Registration District No.

City of Jerome

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Stratton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant

(Write the word.)

6. DATE OF BIRTH

June

3

1929

(Month)

(Day)

(Year)

7. AGE

.....yrs.mos. 20 ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

H. Valentim Hoff Wendall Idaho

10. NAME OF FATHER

Henry L. Stratton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

(State or Country)

Berna Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Gordon Baker

15.

Filed

6/3

1929

Chas F Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 3

1929

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3, 1921, to

June 3, 1921,

1921,

that I last saw him alive on

June 3, 1929,

1929,

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Forceful Delivery.

Intra Cranial Haemorrhage

& Pressure

(Duration)

yrs.

mos.

ds.

Contributory.

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. F. Zeller

M. D.

4/3 1929

(Address)

Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.mos.days.

In the State

.....yrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Idaho

191

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE **RECEIVED JUL 6 1929** STATE OF IDAHO
County of Blaine DEPARTMENT OF PUBLIC WELFARE
City of Paul, Idaho BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S 172466**

No. 845-130-034-369 St. _____
Registration District No. 19 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2015 Local Registrar's No. 101

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	<input checked="" type="checkbox"/> Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other?	and	<input type="checkbox"/> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 30 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? neocelene 15%

Number of child of this mother, including present birth 6 (a) Born alive and now living 3
Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Hyrum Lowell Hunter</u> Residence (Usual place of abode) <u>Paul, Idaho</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>40</u> (Years) Birthplace <u>Paul, Idaho</u> (City and State or Country) Occupation <u>carpenter</u>	MOTHER FULL MAIDEN NAME <u>Adelaich Jane Cozzena</u> Residence (Usual place of abode) <u>Paul, Idaho</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>35</u> (Years) Birthplace <u>Garden, Utah</u> (City and State or Country) Occupation <u>housewife</u>
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CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6:30 P M.
on the date above stated. Stillborn

(Signature) E. E. Elmore

M.D.
(Physician or midwife)

Address Reefers

Filed 7-5-29 E. E. Elmore
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

IN ORBITAL POSITION

Reported by District No.

Police Registration Division, New York City, New York, and Hospital No.

(U) (S) (C) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MM) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)

FULL NAME OF CHILD

(this is even for "drillings" have been collected) (11/11/11)

11/25/51
7:45 PM

to staff
.. itrid

What prophylactic was used to prevent Ophthalmia Neonatorum?

... of child of this mother, including present birth ...

550174

100-443886-1

PATTON

Method 1 - single head - single cell

It is not evident, five place and State.

Color of hair: _____ Age at last birthday: _____

07-08

(Return to page 10)

ПОДПИСАНО:

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

evils and

I hereby certify that I attended the birth of this child, who was ~~born~~ born (at

the date above stated.

(continued)

Physician or midwife

2005/05/14

*When there was no attending physician at midwife, then the latter, non-physician, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life at birth.

2. WHEN A PERSON'S DISABILITY PREVENTS HIM FROM WORKING, HE SHOULD BE HELD RESPONSIBLE FOR HIS DISABILITY. HE SHOULD BE HELD RESPONSIBLE FOR HIS DISABILITY.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth returned.

793-113-0755-789
PLACE RECEIVED JUL 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S 172478**

County of Lewiston
City of Lewiston
No. St Josephs St.
Registration District No. 96 State File No. _____
Prim. Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn. Picavel
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1st</u>	Legitimate? <u>Yes</u>	Date of birth <u>June 13</u> 19 <u>29</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1st (a) Born alive and now living None
Born alive but now dead One Stillborn yes

FATHER FULL NAME <u>Joseph Basil Picavel</u>	MOTHER FULL MAIDEN NAME <u>Mary Magdalen Phillips</u>
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Residence (Usual place of abode) 1017-11th Ave - Lewiston, Ida
Residence (Usual place of abode) 1017-11th Ave - Lewiston, Ida

If nonresident, give place and State _____
If nonresident, give place and State _____

Color or race White Age at last Birthday 30 (Years)
Color or race White Age at last Birthday 32 (Years)

Birthplace Belgium (City and State or Country)
Birthplace Uniontown Wash (City and State or Country)

Occupation Planer
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 A. M. on the date above stated.

(Signature) W O Clark M D

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Lewiston Idaho

Filed July 1, 1929 Susan E. Bruce Registrar.

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66664

County of Myrtle
City of Lewiston

Registration District No. 90
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Basil Vincent Jr.
(a) Residence. No. 1017 - 11th Ave St. 1208
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Infant</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____		
6. DATE OF BIRTH (month, day and year) <u>June 13 - 1929</u>		
7. AGE Years _____ Months _____ Days _____	If LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____ <u>Infant</u>		

9. BIRTHPLACE (city or town) (State or country) <u>Lewiston Idaho</u>	PARENTS
10. NAME OF FATHER <u>Basil Vincent</u>	
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Austria</u>	
12. MAIDEN NAME OF MOTHER <u>Lena Phillips</u>	
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>	PARENTS
14. Informant <u>Basil Vincent</u> (Address) <u>Lewiston Idaho</u>	
15. Filed <u>July 1</u> , 19 <u>29</u> <u>Susan E Bruce</u> Registrar	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH <u>June 12</u> 19 <u>29</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h. _____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Stillborn</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY (Secondary) <u>unknown</u> (duration) _____ yrs. _____ mos. _____ ds.	
18. Where was disease contracted if not at place of death? _____ Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? _____ (Signed) <u>W O Clark</u> M. D. <u>6/18/29</u> (Address) <u>Lewiston Idaho</u>	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation or Removal <u>Lewiston Idaho</u>	Date of Burial <u>6/13</u> 19 <u>29</u>
20. Undertaker <u>Vassar's</u>	Address <u>Lewiston Idaho</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

386-109-036-243
PLACE OF BIRTH

RECEIVED JUL 5 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida
City of Malad
No. 26 St. 2064 Registration District No. 172535 State File No. 66
Hospital Stillbirth Primary Registration District No. Thornton Local Registrar's No. 66
FULL NAME OF CHILD Stillbirth Thornton
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth 1 Legitimate? yes Date of birth May 9 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Ag No 3

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL MAIDEN NAME Edward Thornton
RESIDENCE Malad, Ida.
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Malad, Ida.
OCCUPATION shoemaker

MOTHER
FULL MAIDEN NAME Viella Butler
RESIDENCE Malad, Ida.
COLOR white AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Hosper, Utah
OCCUPATION housewife

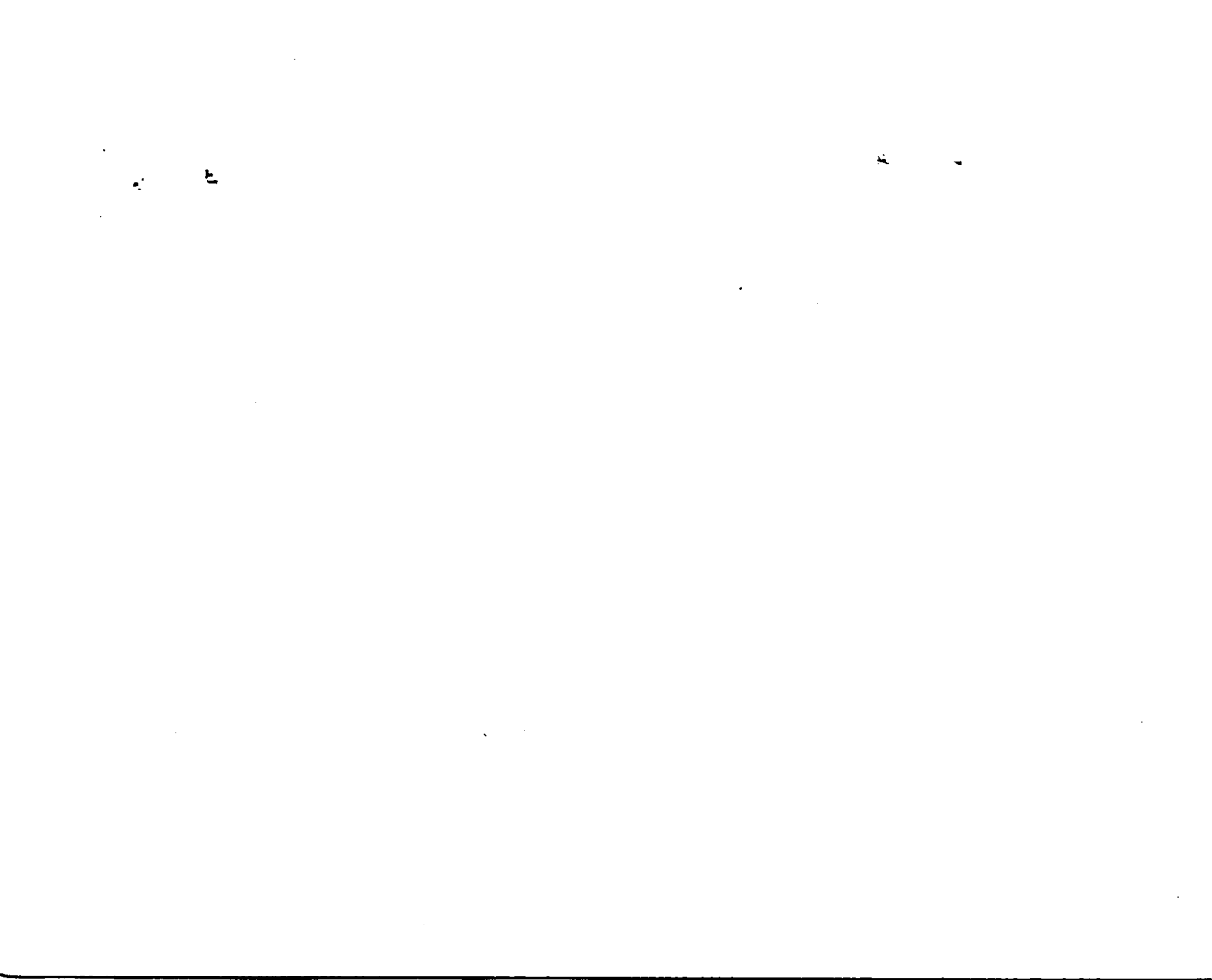
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 1 00 P. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) V. P. Earst
Physician
(Physician or midwife)

Address Malad, Ida.
Filed 6/30 1929 J. M. Kerns
Registrar. Registrar.



RECEIVED JUN 6 1929 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Oneida*
City of *Malad*Registration District No. *26*Primary Registration District No. *2069*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Stillborn Thornton*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *66300*
Registered No. *7*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male White**Child*
(write the word.)

6. DATE OF BIRTH

May - 9 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Malad Ida.

10. NAME OF FATHER

Edmund Thornton

11. BIRTHPLACE OF FATHER

(State or Country)

Portville Ida.

12. MAIDEN NAME OF MOTHER

Viella Jay Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Thornton
Malad Ida.

(Address)

15.

Filed

5/31 1929 J. M. Kerns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May - 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9, 1929, to 19
that I last saw him alive on *May 9* 19
and that death occurred on the date stated above, at *about May 9* M.

The CAUSE OF DEATH* was as follows:

Stillborn. Due to cord around neck twice.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

V. O. Gant

M. D.

May 9, 1929 (Address) *Malad, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida. May 10, 1929

20. UNDERTAKER

ADDRESS

J. Guy Benson Malad Ida.

36 157

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

643-10.038-389
RECEIVED JUN 28 1929

County of Payette.
City of Payette.
No. _____ St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

172549

Registration District No. 4 State File No. _____
(If born in hospital or institution give name.)
Prim. Registration District No. 1008 Local Registrar's No. 39

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>June 1, 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silvol

Number of child of this mother, including present birth 3 (a) Born alive and now living 1
Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Ward W. Fuller
Residence (Usual place of abode) Payette, Idaho
If nonresident, give place and State ----
Color or race White Age at last Birthday 38 (Years)
Birthplace Minnesota
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Irene Thiel
Residence (Usual place of abode) Payette, Idaho
If nonresident, give place and State -----
Color or race White Age at last Birthday 22 (Years)
Birthplace Idaho.
(City and State or Country)
Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

Stillborn

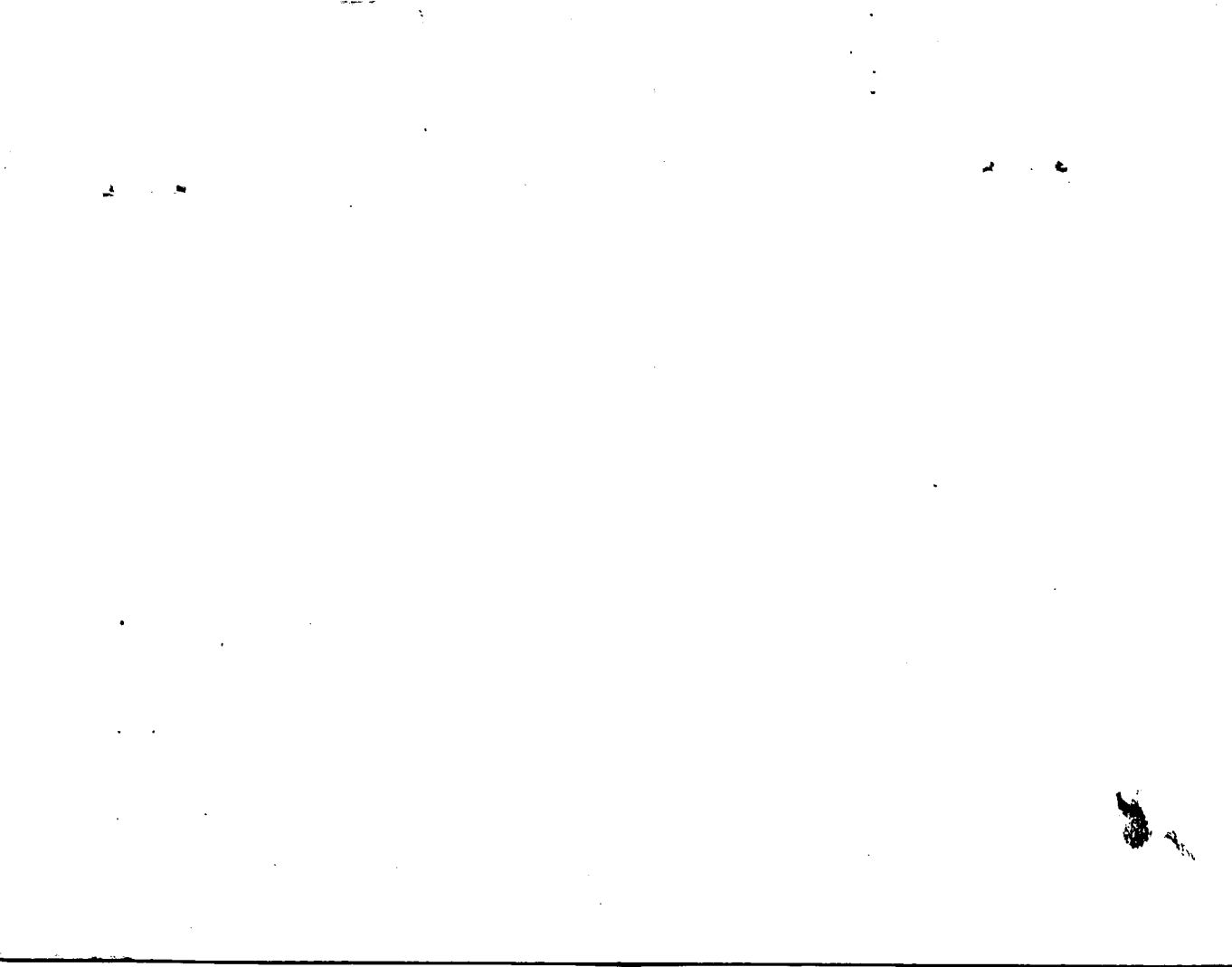
I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 3.30 p.m. M.

(Signature) J. C. Woodward
Physician.
(Physician or midwife)

Address Payette, Idaho.

Filed June 1 19 29
Registrar J. C. Woodward

{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }



RECEIVED JUN 28 1929

PLACE OF DEATH

County of PAYETTE.City of PAYETTE.STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 4Primary Registration District No. 1008

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn infant of Ward W. Fuller.(a) Residence. No. 917 North 6th. St. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Infant</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -----		
6. DATE OF BIRTH (month, day and year) <u>June 1, 1929</u>		
7. AGE Years -----	Months -----	Days ----- If LESS than 1 day, hrs. or ----- min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. ----- (b) General nature of industry, business, or establishment in which employed (or employer) ----- (c) Name of employer -----		

9. BIRTHPLACE (city or town) Payette, Idaho
(State or country)

10. NAME OF FATHER <u>Ward W. Fuller</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Minnesota.</u>
12. MAIDEN NAME OF MOTHER <u>Irene Theil.</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>

14. Informant Ward W. Fuller
(Address) Payette, Idaho15. Filed June 3, 1929 J.C. Woodward
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 66686Local Registrar's No. 22

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 1, 1929
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
June 1, 1929, 19____, to June 1, 1929, 19____that I last saw him alive on June 1, 1929, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Smallpox immediately preceeding
birth of infant in the mother

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J.C. Woodward, M. D.
6/3/29, 19____ (Address) Payette, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal
Payette, Idaho Date of Burial
6/2/29 19____20. Undertaker
Ward W. Fuller Address
Payette, Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

523-127-042-764

PLACE OF BIRTH

RECEIVED JUL 10 1929

STATE OF IDAHO

County of Twin Falls

DEPARTMENT OF PUBLIC WELFARE

City of Twin Falls

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. St.

T. F. Carlsen

Registration District No. 37 State File No. S 172633

(If born in hospital or institution
give name.)

Prim. Registration District No. 1086 Local Registrar's No.

FULL NAME OF CHILD Still birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 27</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Carl R. Estensen</u>	FULL MAIDEN NAME <u>Marguerite Pomeroy</u>

Residence (Usual place of abode) Buhl Bldg

If nonresident, give place and State

Color or race W Age at last Birthday 27 (Years)

Birthplace Michigan (City and State or Country)

Occupation Store Manager

Color or race W Age at last Birthday 28 (Years)

Birthplace Oregon (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3:30 M. on the date above stated. Stillborn

(Signature) M. Davis

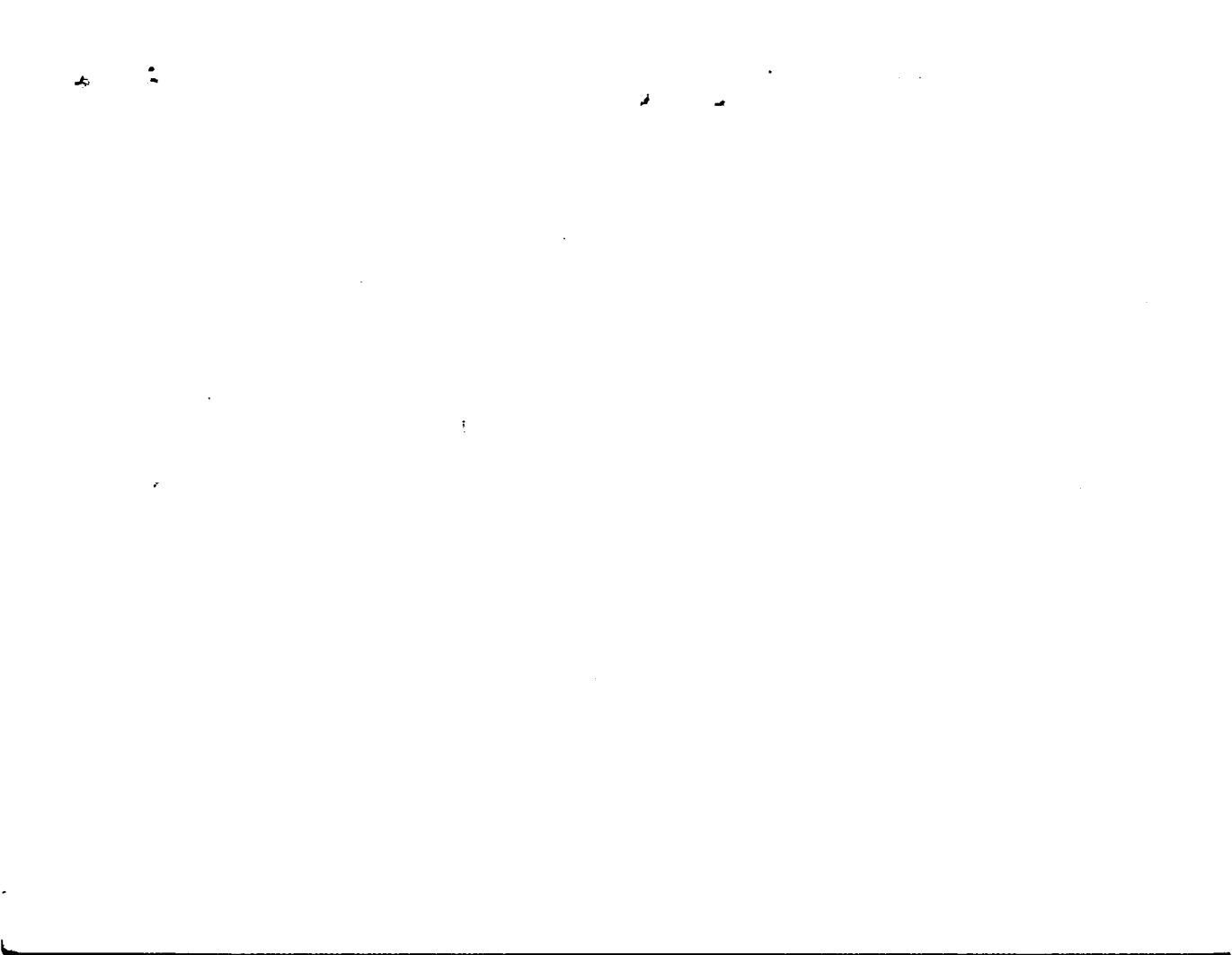
(Physician or midwife)

Address Kimberly, Ida.

Filed 7-10 1929 H. Y. Leete

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66723

PLACE OF DEATH *Twin Falls*
County of *Twin Falls* Registration District No. *37*
City of *Co. Genl. Hospital* Primary Registration District No. *1085*
Twin Falls

Local Registrar's No. *no 6*

(No. *106*)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Estensen*(a) Residence. No. *Buhl Idaho* St.

(Usual place of abode)
Length of residence in city or town where death occurred. *0* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of *✓*

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *0*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Twin Falls, Ida.*
(State or country)10. NAME OF FATHER *Carl R. Estensen*11. BIRTHPLACE OF FATHER (city or town) *Mich.*
(State or Country)12. MAIDEN NAME OF MOTHER *Margaret Pauray*13. BIRTHPLACE OF MOTHER (city or town) *Oregon.*
(State or Country)14. Informant *C. R. Estensen*
(Address) *Buhl Ida*15. Filed *7-10*, 19*29* *H. M. Lutz*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 27 19*29*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 27, 19*29*, to *June 27*, 19*29*
that I last saw him alive on _____ 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still birth

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary) *Compression of*
cord in fetal canal
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? *✓*Did an operation precede death? *✓* Date of _____Was there an autopsy? *✓*What test confirmed diagnosis? *✓*(Signed) *J. R. Pauray* M. D.*6/28*, 19*29* (Address) *Kimberly*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Twin Falls Ida Date of Burial *6/28* 19*29*

20. Undertaker *J. R. Pauray* Address *Buhl Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

577-207 042-365

PLACE OF BIRTH RECEIVED

JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 172679

County of Twin Falls
City of Twin Falls
No. _____ St. _____

Registration District No. 37 State File No. _____

Prim. Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>✓</u> (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>June 7 1929</u> (Month) (Day) (Year)
----------------------------	--	-------	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living No

Born alive but now dead _____ Stillborn Stillborn

FATHER
FULL NAME George H Eggert

Residence (Usual place of abode) Twin Falls

If nonresident, give place and State ✓

Color or race White Age at last Birthday 22
(Years)

Birthplace Milwaukee, Wis.
(City and State or Country)

Occupation Capt. Salvation Army

MOTHER
FULL MAIDEN NAME Velma May Long

Residence (Usual place of abode) Twin Falls

If nonresident, give place and State ✓

Color or race White Age at last Birthday 22
(Years)

Birthplace Redway Oregon
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P.M.
on the date above stated.

(Signature) J E Langerwaller
Twin Falls Idaho
(Physician or midwife)

Address _____

Filed 7-10 1929 JH
Registrar,

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. 1

2. 2

RECEIVED JUL 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66711

PLACE OF DEATH

County Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Eggert

(a) Residence No. _____ St. _____

(b) Usual place of abode _____

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) June 7 / 29

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. Still

8. OCCUPATION OF DECEASED _____

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Idaho

10. NAME OF FATHER G. H. Eggert

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Velma Long

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant G. H. Eggert
(Address) Twin Falls

15. Filed 7-10, 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) June (Day) 7 (Year) 1929

17. I HEREBY CERTIFY, That I attended deceased from

June 7, 1929, to June 17, 1929

that I last saw her alive on do, 1929

and that death occurred, on the date stated above, at 8:20 P. M.

The CAUSE OF DEATH* was as follows:

Still born.
Premature Torsioned Placenta.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? none

(Signed) J. C. Langenswally, M. D.

June 31, 1929 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Twin Cemetery 19

20. Undertaker Address

H. Drake Twin Falls

172679 MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

466-223 204-255
PLACE OF BIRTH

RECEIVED AUG 5 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
172743

County of Boise
City of Boise

No. Salphansus St.

(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 172743

Prim. Registration District No. 1004 Local Registrar's No. 279

FULL NAME OF CHILD Shirley Benson Moody

Stillborn, substitute the word "Stillbirth" for name of child

Sex of
Child Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth June 24

(Month)

(Day)

1929
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? a

Number of child of this mother, including present birth none (a) Born alive and now living none

Born alive but now dead none Stillborn one

FATHER

FULL NAME Ivan Vance Moody

Residence (Usual place of abode) 1107 State

If nonresident, give place and State

Color or race W. Age at last Birthday 23
(Years)

Birthplace Germ. Idaho
(City and State or Country)

Occupation Oakley, Idaho - Farmer

FULL
MAIDEN
NAME

MOTHER

Laura
Isabelle Benson

Residence (Usual place of abode) same

If nonresident, give place and State

Color or race W. Age at last Birthday 21
(Years)

Birthplace Ogden, Utah
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:15 a. M.
on the date above stated.

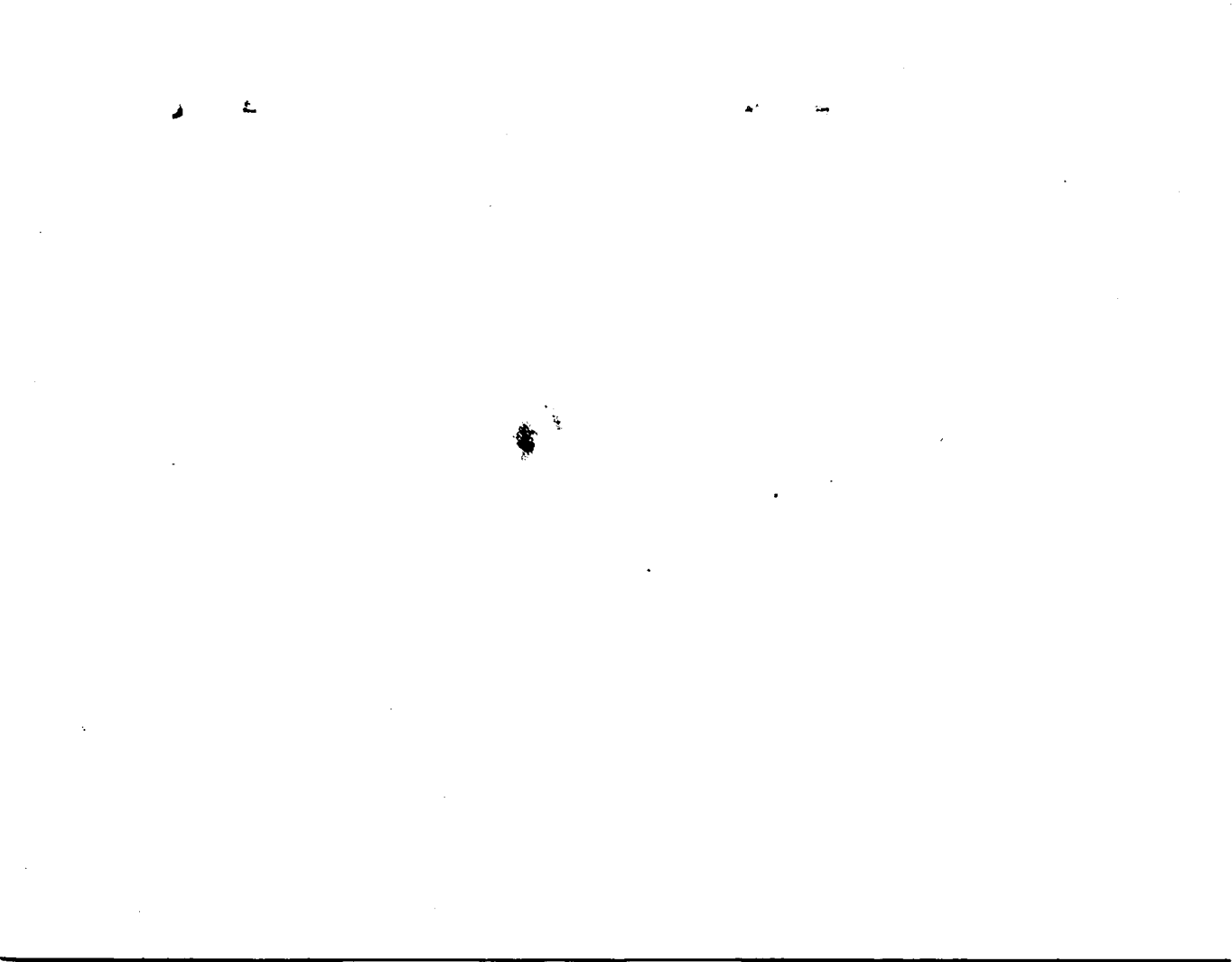
(Signature) Alfred H. Budge
Per M.B.K.
(Physician or midwife)

Address Boise Idaho

Filed 7/3 1929 W. N. Rhodes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 66384

RECEIVED JUL 6 1929
PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 170

2. FULL NAME Shirley Moody
(a) Residence, No. St
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>		
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -----				
6. DATE OF BIRTH (month, day and year) <u>June 23rd 1929</u>				
7. AGE <u>0</u>	Years <u>0</u>	Months <u>0</u>	Days <u>0</u>	If LESS than 1 day, ----- hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

PARENTS	
9. BIRTHPLACE (city or town) (State or country)	<u>Boise, Idaho</u>
10. NAME OF FATHER	<u>I. V. Moody</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country)	<u>Mo.</u>
12. MAIDEN NAME OF MOTHER	<u>Isabel Benson</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)	<u>Odgen</u>
14. Informant	<u>Mrs. H. J. Benson</u>
(Address)	<u>Seattle, Wash.</u>
15. Filled <u>6/26/29</u>	<u>W. N. Rhodes</u> Registrar

MEDICAL CERTIFICATE OF DEATH		
16. DATE OF DEATH <u>June 23rd 1929</u> (Month) (Day) (Year)		
17. I HEREBY CERTIFY, That I attended deceased from <u>June 23</u> , 19 <u>29</u> , to <u>June 23</u> , 19 <u>29</u> , that I last saw <u>her</u> alive on <u>June 23</u> , 19 <u>29</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* <u>as follows:</u> <u>Premature Birth</u>		
(duration) _____ yrs. _____ mos. _____ ds.		
CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.		
18. Where was disease contracted if not at place of death? Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>Physical findings</u> (Signed) <u>Alfred E. Jones</u> , M. D. <u>6/24/29</u> , 19 <u>29</u> (Address) <u>Boise, Idaho</u>		
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
19. Place of Burial, Cremation, or Removal <u>Morris Hill Cemetery</u>	Date of Burial <u>6/23/29</u> 19 <u>29</u>	
20. Undertaker <u>Wm. McBratney</u>	Address <u>Boise, Ida.</u>	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of high stated.

PLACE OF BIRTH

RECEIVED AUG 5 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 172753

County of.....

City of.....

No. St.

769-713-001-199

(If born in hospital or institution
give name.)

Registration District No. State File No.

Prim. Registration District No. 2004 Local Registrar's No. 51

FULL NAME OF CHILD Still birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>y.</u>	Date of birth <u>7 13 1929</u> (Month) (Day) (Year)
-----------------------	---	---	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Born dead

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn one

FATHER	MOTHER
FULL NAME <u>Joe Garris</u>	FULL MAIDEN NAME <u>Pilar Arriola</u>
Residence (Usual place of abode) <u>Boise</u>	Residence (Usual place of abode) <u>same</u>
If nonresident, give place and State <u>Idaho</u>	If nonresident, give place and State <u>Idaho</u>
Color or race <u>W.</u> Age at last Birthday <u>36</u> (Years)	Color or race <u>W.</u> Age at last Birthday <u>26</u> (Years)
Birthplace <u>Spain</u> (City and State or Country)	Birthplace <u>Spain</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Farmer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 7 P. M.
on the date above stated. { Stillborn }

(Signature)

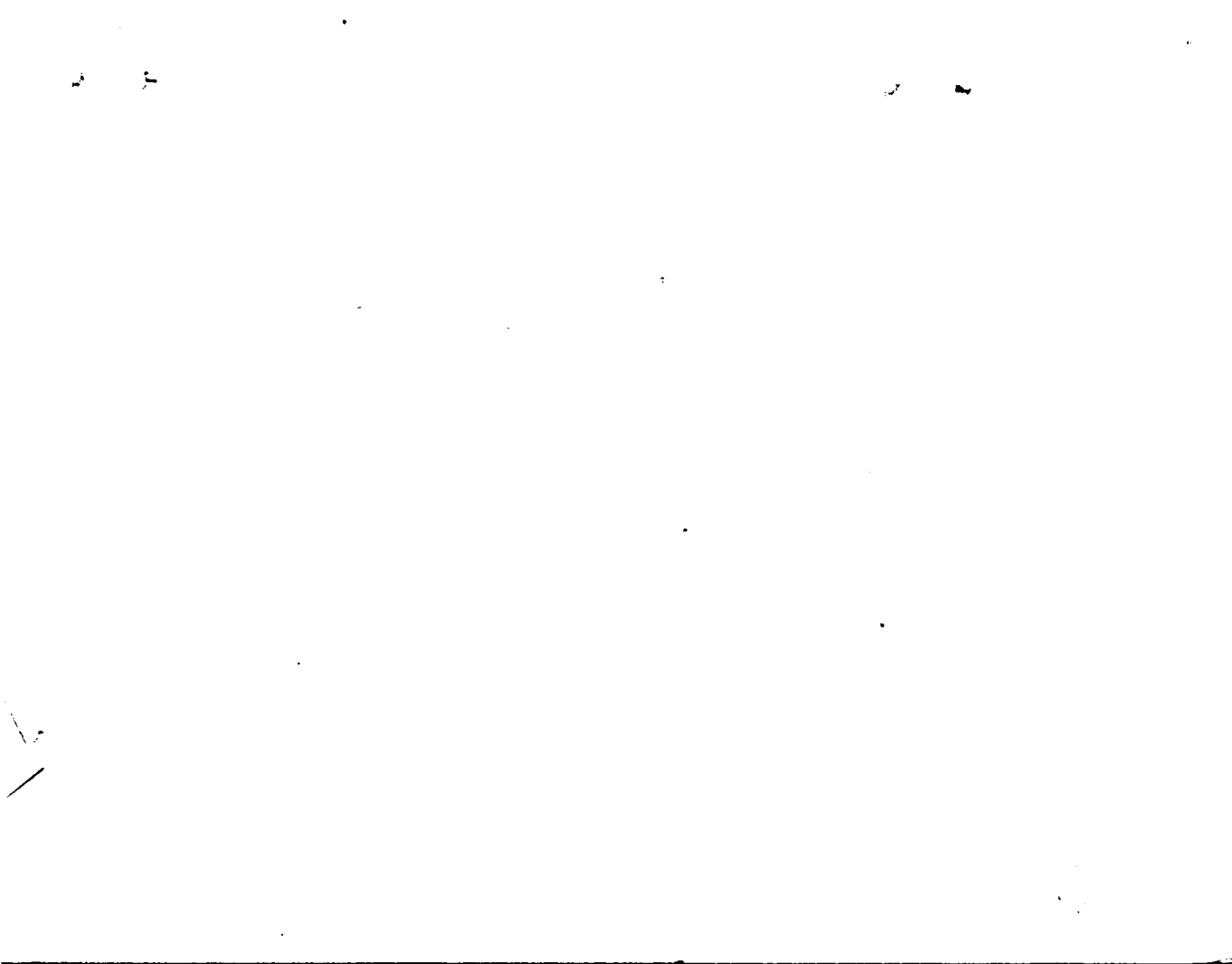
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 7/19 1929 W.H. Rhodes

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66767

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004

Local Registrar's No. 53

(No.)
If death occurred in a hospital or institution, give its name instead of street and number.

2. FULL NAME

(a) Residence. No. Two Miles South of Boise St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Male

4. COLOR OR RACE

Wht

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day,
Premature Stillborn min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant José Gairi
(Address) Boise Ada15. Filed 7/17, 1929 W. H. Phoebe
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

713'29

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19____, to____, 19____

that I last saw h____ alive on____, 19____

and that death occurred, on the date stated above, at____m.

The CAUSE OF DEATH* was as follows:

'Stillborn', two days before
birth the mother fell on abdomen
fetus macerated.

(duration) ____yrs. ____mos. ____ds.

CONTRIBUTORY
(Secondary)accident to mother

(duration) ____yrs. ____mos. ____ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) aj. Coats, M. D.

____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

St Johns Cemetery7-15- 1929

20. Undertaker

Address

Schwiber McCannBoise Ada

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth returned.

PLACE OF BIRTH -

County of.....

City of.....

No. St.

396-115-703-293

(If born in hospital or institution
give name.)

Registration District No.....

State File No.....

172834

Prim. Registration District No.....

Local Registrar's No. 247

FULL NAME OF CHILD.....

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Male

Twin
Triplet
or other?
(To be answered only in event of plural births)and { Number
in order
of birthLegiti-
mate?

yes

Date of
birth

May 15

(Month) (Day)

1929 (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Ag No. 3

Number of child of this mother, including present birth

7

(a) Born alive and now living

3

Born alive but now dead

7

Stillborn

3

FATHER
FULL
NAME

Leven Cornwell

Residence (Usual place of abode)

Pocatello

If nonresident, give place and State

Color or race

White

Age at last Birthday

28 (Years)

Birthplace

Idaho

(City and State or Country)

Occupation

P. S. R. R.

MOTHER
FULL
MAIDEN
NAME

Vera Siler

Residence (Usual place of abode)

Pocatello

If nonresident, give place and State

Color or race

White

Age at last Birthday

28 (Years)

Birthplace

Utah

(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.Born alive
Stillborn

at 5/15/29 M.

(Signature)

C. P. Y. Siler

Pocatello

(Physician or midwife)

Address

Box 63 Pocatello

Filed

6/1 1929

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

795 130 003 466
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello

CERTIFICATE OF BIRTH

No. _____ St. _____
Hospital St. Anthony

Registration District No. 28

File No. 172836

Primary Registration District No. 2161

Registered No. 9325

FULL NAME OF CHILD

Still born

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	{ and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth. <u>June 30</u> 192 <u>9</u> (Month) (Day) (Year)
--------------------------	--	---	-----------------------------	---

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth... 2 Number of children of this mother now living, including present birth... 1

FULL NAME FATHER Oscar Hewitt
RESIDENCE Pocatello
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Arkansas
OCCUPATION uphol

FULL MAIDEN NAME MOTHER Delphia Moore
RESIDENCE Idaho
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Mo.
OCCUPATION W.D.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was at M.
on the date above stated. (Born alive or stillborn)

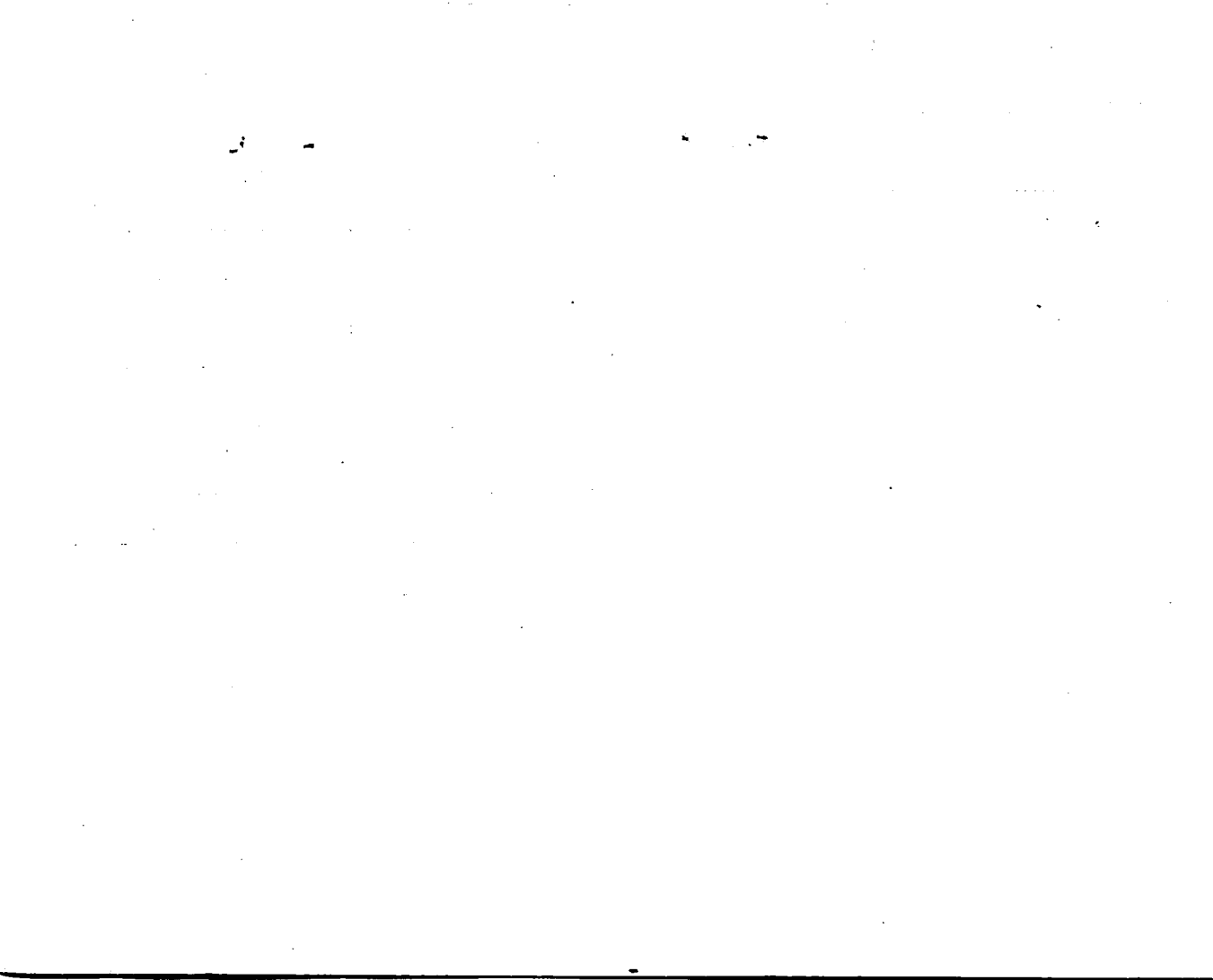
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. P. Miller

Give names added from a supplemental report.

(Physician or midwife)
Address 310 E. Center St. Pocatello

Filed 7/1 1929 Almon
Registrar. Registrar.



172836

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

JUL 20 1929

PLACE OF DEATH

County of BANNOCK

City of POCATELLO

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2461

(No. ST ANTHONY HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 66824

Local Registrar's No. 5607

2. FULL NAME INFANT PREWITT

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX <u>MALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>SINGLE</u>
-----------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) JUNE 29, 1929

7. AGE <u>STILL BORN</u>	Years Months Days	If LESS than 1 day, hrs. or min.
-----------------------------	-------------------------	-------------------------------------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO,
(State or country) IDA.

10. NAME OF FATHER OSCAR PREWITT

11. BIRTHPLACE OF FATHER (city or town) ARKANSAS
(State or Country)

12. MAIDEN NAME OF MOTHER DELPHIA MOORE

13. BIRTHPLACE OF MOTHER (city or town) MISSOURI
(State or Country)

14. Informant OSCAR PREWITT
(Address) 271- JEFFERSON ST.

15. Filed 6/30, 1929 Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH JUNE 29, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to June 29, 1929
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Puerperal Complica
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis?
(Signed) F. S. Miller, M. D.
6/30, 1929 (Address) Pocatello, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>MOUNTAIN VIEW CEMETERY</u>	Date of Burial <u>6-30-1929</u>
20. Undertaker <u>ARTHUR W. HALL</u>	Address <u>POCATELLO</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

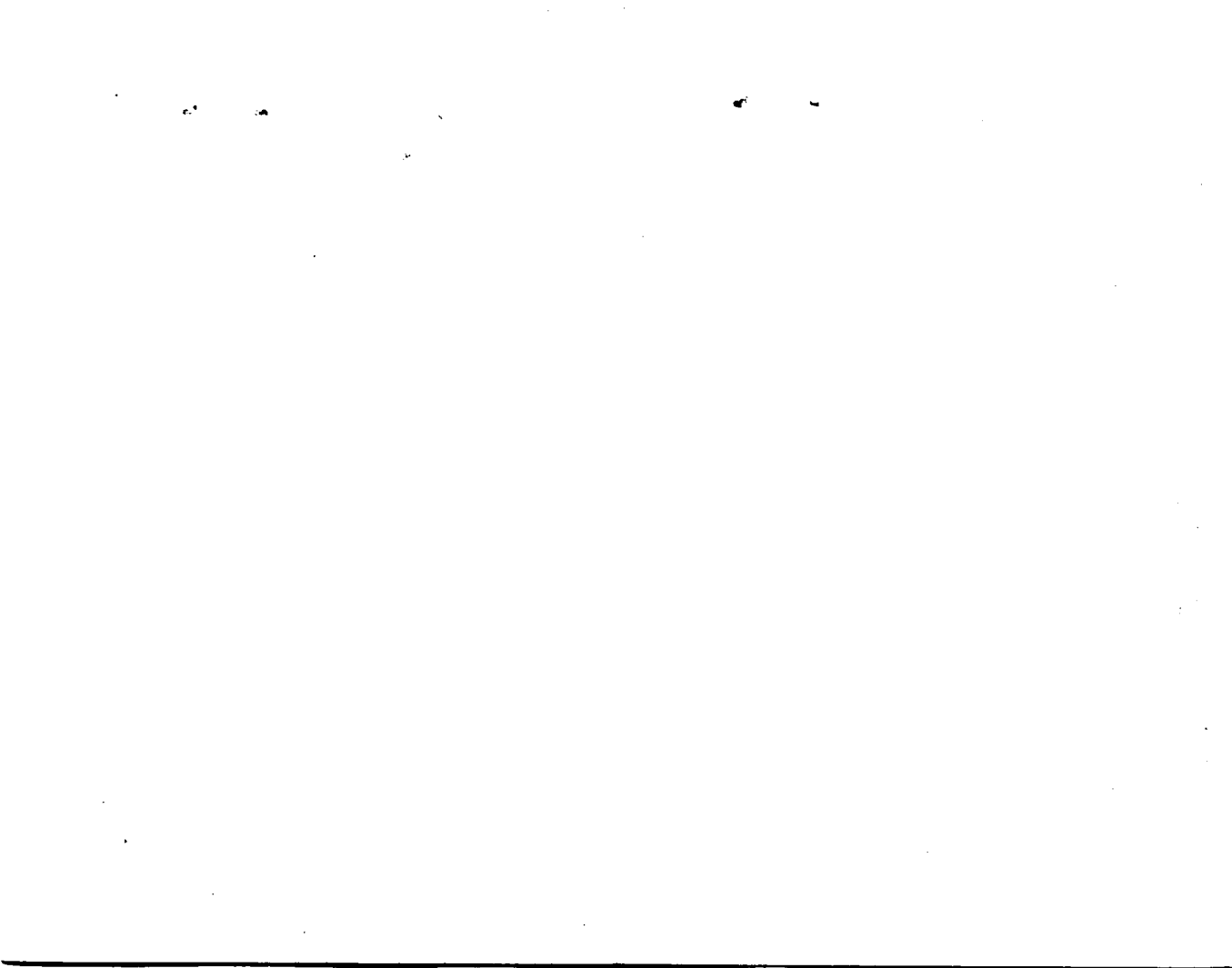
Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Bannock</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Pocatello</u>		BUREAU OF VITAL STATISTICS	
No. <u>St. Anthony</u> St.		CERTIFICATE OF BIRTH	
<u>386-205-003-813</u>		Registration District No. <u>28</u>	State File No. <u>172845</u>
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2161</u>	Local Registrar's No. <u>93/6</u>
FULL NAME OF CHILD <u>Stillborn.</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>
		Date of birth <u>6-25-1929</u>	(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?			
Number of child of this mother, including present birth <u>1</u> (a) Born alive and now living <u>1</u>			
Born alive but now dead <u>0</u> Stillborn <u>0</u>			
FATHER		MOTHER	
FULL NAME <u>Glen E. Thomas</u>		FULL MAIDEN NAME <u>Tessie Hackworth</u>	
Residence (Usual place of abode) <u>Montpelier</u>		Residence (Usual place of abode) <u>Montpelier, Ida</u>	
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>W</u> Age at last Birthday <u>23</u>		Color or race <u>W</u> Age at last Birthday <u>22</u>	
Birthplace <u>Pocatello, Ida.</u> (City and State or Country)		Birthplace <u>Piedmont Missouri</u> (City and State or Country)	
Occupation <u>Salesman Skaggs</u>		Occupation <u>H. W.</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was { Born alive } at <u>6 45</u> P. M.			
on the date above stated.			
(Signature) <u>O. Head</u>			
{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }			
Address <u>Pocatello, Idaho</u>			
Filed <u>7/1 1929</u> <u>Young</u> Registrar.			



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 20 1929

PLACE OF DEATH

County of PocahontasCity of Pocahontas

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 28Primary Registration District No. 2141(No. St Anthony's Hosp)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5606

2. FULL NAME

(a) Residence. No. Mont Pelier

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OF RACE

white5. Single, Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

June 25, 29

7. AGE

Years Months Days

If LESS than 1 day,

Still Born

hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of worknone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Pocahontas Idaho

10. NAME OF FATHER

Glen E. Thomas11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Pocahontas

12. MAIDEN NAME OF MOTHER

Tessie Backus13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Piedmont Mo.

14. Informant

(Address)

Glen E. ThomasMont Pelier, Ida

15. Filed

June 26, 29

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26

(Month)

(Day)

1929
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 1929, to1929

that I last saw him alive on

1929

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Still BornDue to Strangulation by Cord

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

June 26, 29(Address) PocahontasState the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pocahontas, Ida. Jan 26, 29

20. Undertaker

Address

Howards Undertaking Co. Pocahontas

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Bannock</u>	RECEIVED JUL 20 1929	DEPARTMENT OF PUBLIC WELFARE	
City of <u>Pocatello</u>		BUREAU OF VITAL STATISTICS	
No.	St.	CERTIFICATE OF BIRTH	
<u>119-130003-395</u>		Registration District No. <u>28</u>	State File No. <u>172864</u>
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2161</u>	Local Registrar's No. <u>9222</u>
FULL NAME OF CHILD <u>Jarvis</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mated <u>Yes</u>
		Date of birth <u>May 30</u>	<u>1929</u>
		(Month) (Day) (Year)	
What prophylactic was used to prevent Ophthalmia Neonatorum <u>Neo-Silva</u>			
Number of child of this mother, including present birth <u>1</u> (a) Born alive and now living <u>0</u>			
Born alive but now dead _____ Stillborn _____			
FATHER FULL NAME <u>Robert T. Jarvis</u>		MOTHER FULL MAIDEN NAME <u>Ernestine Creshaw</u>	
Residence (Usual place of abode) <u>Pocatello, Ida</u>		Residence (Usual place of abode) <u>Pocatello, Ida</u>	
If nonresident, give place and State _____		If nonresident, give place and State _____	
Color or race <u>White</u>	Age at last Birthday <u>✓</u>	Color or race <u>White</u>	Age at last Birthday <u>✓</u>
(Years)		(Years)	
Birthplace <u>Chicago, Illinois</u>	(City and State or Country)	Birthplace <u>Montana</u>	(City and State or Country)
Occupation <u>✓</u>		Occupation <u>Housewife</u>	

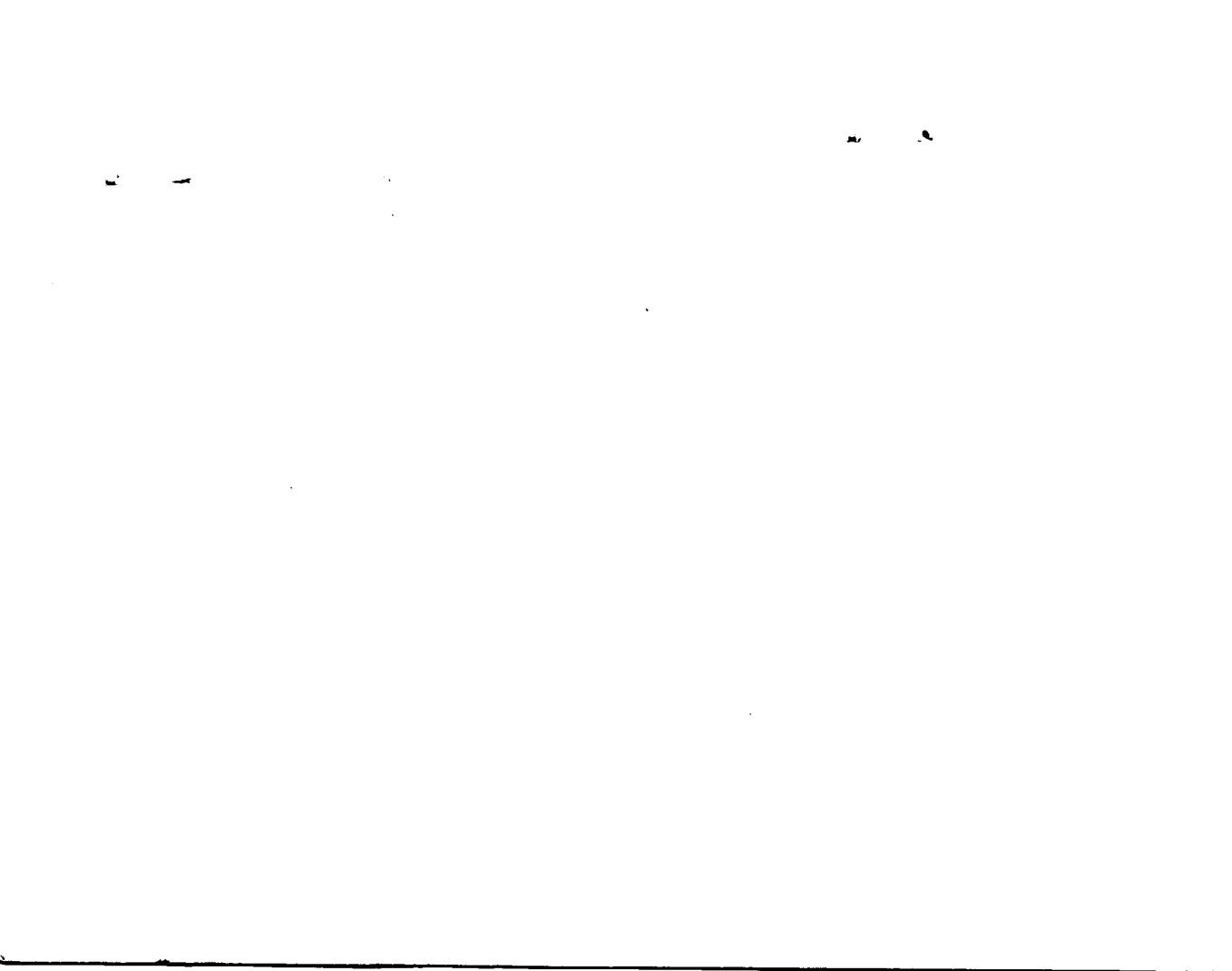
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at _____ M.
on the date above stated.

(Signature) Dr. O'Brien
Pocatello
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____
Filed 6/1 1929 RP
Registrar.



MARGIN RESERVED FOR BINDING

172864 +

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Call

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED JUL 20 1929
PLACE OF DEATH
COUNTY OF Blaine
CITY OF Boise
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 86803

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5580

(No. Boise General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Yarnia
(a) Residence No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX <u>Male</u>	4. COLOR OF RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u> </u>		
6. DATE OF BIRTH (month, day, year) <u>May 30 1929</u>		
7. AGE Years <u>5</u> Months <u> </u> Days <u> </u>	If LESS than 1 day, min. <u> </u> hrs. or <u> </u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> (c) Name of employer <u> </u>		

9. BIRTHPLACE (city or town) (State or country) <u>Boise Idaho</u>	PARENTS
10. NAME OF FATHER <u>Mr. T. Yarnia</u>	
11. BIRTHPLACE OF FATHER (city or town) (State or country) <u>Chicago Ill.</u>	
12. MAIDEN NAME OF MOTHER <u>Christina Greenhaw</u>	
13. BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Boise Idaho</u>	
14. Informant <u>Dr. T. Yarnia</u> (Address) <u>Boise Idaho</u>	
15. Filled <u>5/31</u> , 19 <u>29</u> <u> </u> Registrar	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH <u>May 30 1929</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>May 30</u> , 19 <u>29</u> , to <u>May 30</u> , 19 <u>29</u> that I last saw him alive on <u>May 30</u> , 19 <u>29</u> and that death occurred, on the date stated above, at <u> </u> m. The CAUSE OF DEATH* was as follows: <u>Still born -</u> <u>Due to hydrocephalus</u> <u>Bones of skull unossified</u> (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) <u> </u> (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Did an operation precede death? <u> </u> Date of <u> </u> Was there an autopsy? <u> </u> What test confirmed diagnosis? <u> </u> (Signed) <u>Dr. T. Yarnia</u> , M. D. <u>5/31</u> , 19 <u>29</u> (Address) <u>Boise Idaho</u>

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Reburial <u>Mountain View</u>	Date of Burial <u>May 31 1929</u>
20. Undertaker <u>H. B. McMan</u>	Address <u>Boise Idaho</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED AUG 7 1929
County of Melba

City of Conway

No. 795-124 017 4169 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
173016

Registration District No. 2 State File No. 2006

Prim. Registration District No. 2006 Local Registrar's No. 175

FULL NAME OF CHILD "Still birth"
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>m</u>	Twin <u>S</u> } and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>7 - 24</u> <u>1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME James Bryan Piesal
Residence (Usual place of abode) Melba, Idaho
If nonresident, give place and State _____
Color or race Am. Age at last Birthday 31 (Years)
Birthplace Idaho (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Mattie Olive Piesal
Residence (Usual place of abode) Melba, Idaho
If nonresident, give place and State _____
Color or race Am. Age at last Birthday 26 (Years)
Birthplace Idaho (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 P. M.
on the date above stated. { Stillborn }

(Signature) J. C. Horton

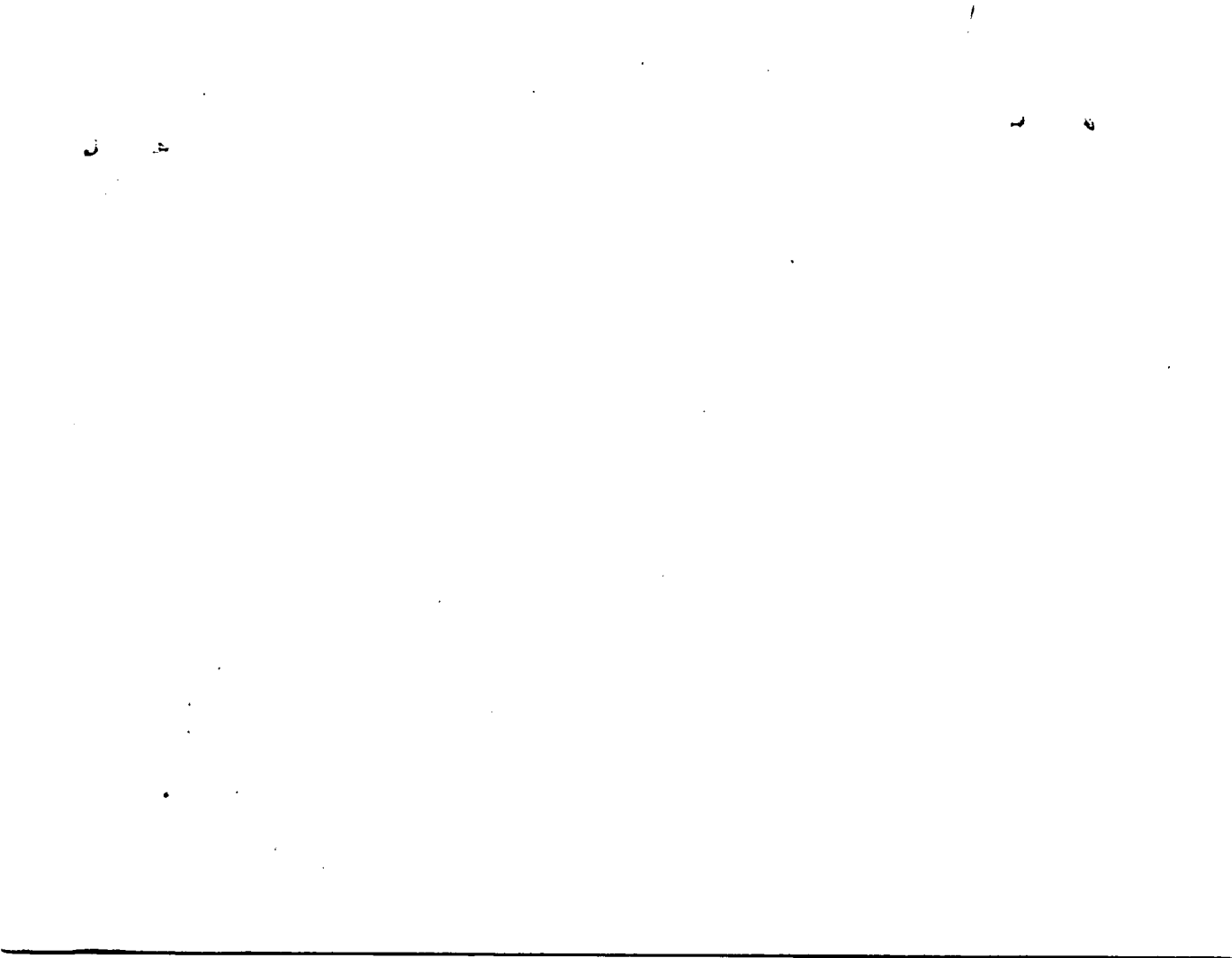
(Physician or midwife)

Address Nampa, Idaho

Filed 8/5-29 Betha Conway

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 10 1929

PLACE OF DEATH

County of CANYONCity of MELBASTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 7
Primary Registration District No. 2006

DO NOT WRITE IN THIS SPACE

State File No. 67310Local Registrar's No. 88(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME INFANT son of MR. & MRS. JAMES B. PEIRSOL(a) Residence. No. MELBA? IDAHO. St. _____(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX MALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) #####5a. If married, widowed, or divorced HUSBAND of (or) WIFE of #####6. DATE OF BIRTH (month, day and year) 7.25, 19297. AGE Years Months Days If LESS than 1 day, hrs. or min. 0 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work #####

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) MELBA? IDAHO.
(State or country)10. NAME OF FATHER JAMES B. PEIRSOL11. BIRTHPLACE OF FATHER (city or town) NEBR.
(State or Country)12. MAIDEN NAME OF MOTHER MATTIE DORAMUS13. BIRTHPLACE OF MOTHER (city or town) KANSAS
(State or Country)14. Informant James B. Peirsol
(Address) Melba, Idaho15. Filed 7-26, 1929 Satin Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7.25, 1929.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 7-25, 1929, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Still born.
Intra-uterine death.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted ✓
if not at place of death?Did an operation precede death? ✓ Date of ✓Was there an autopsy? ✓What test confirmed diagnosis? ✓(Signed) J. E. Horton, M. D.
7-6, 1929 (Address) Banger

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

KOHLERLAWN CEMETRY 7, 26, 192920. Undertaker Address
FRED. K. ROBINSON NAMPA? IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

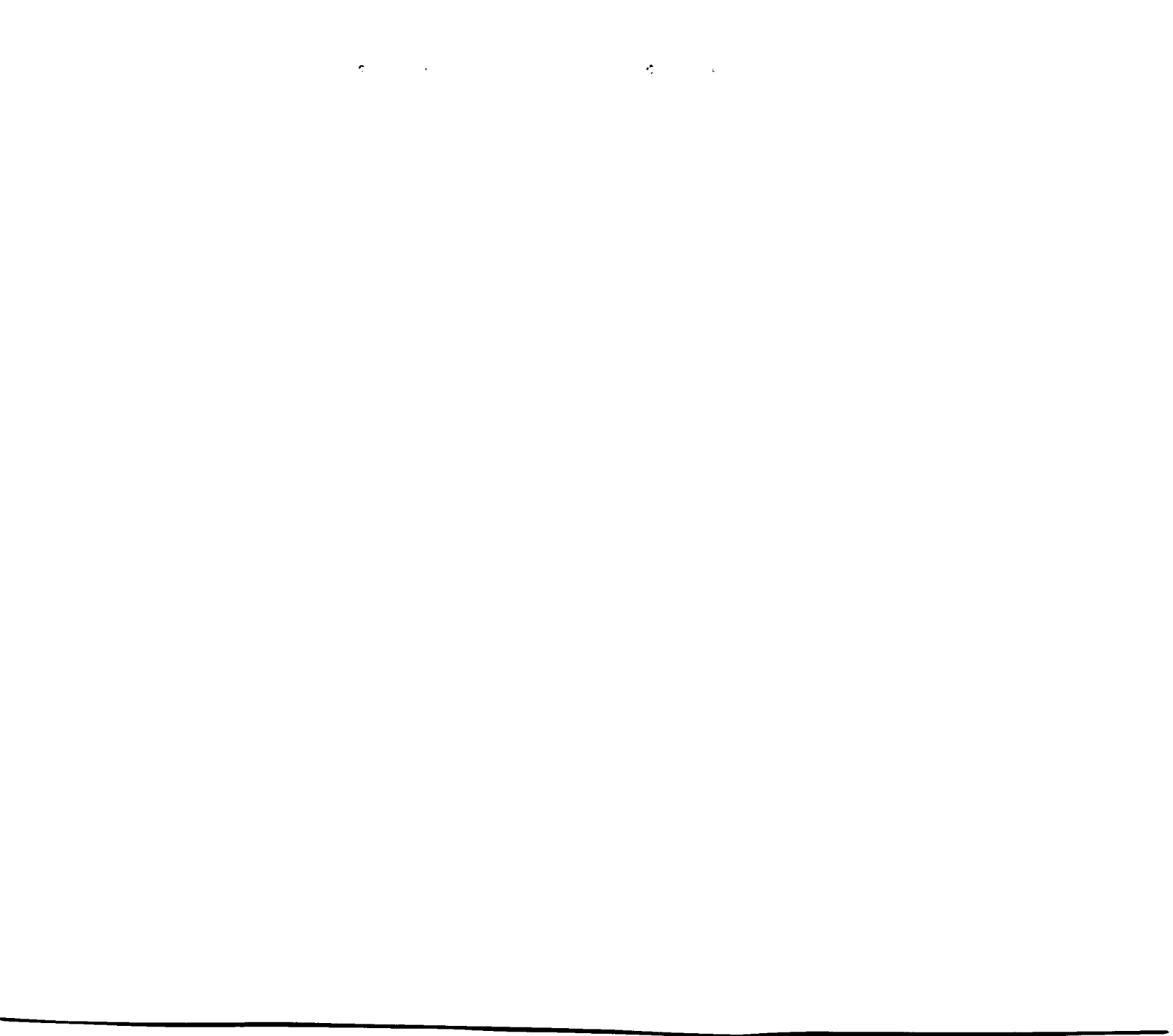
Do not accept a certificate of death signed only by a midwife.

FILE # 173039

YEAR 1929

IDAHO STILLBIRTH CERTIFICATE

**☒ VOID DUP OF STILLBIRTH
1929-172156**



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 9 1929
County of Fremont STATE OF IDAHO
City of Chester DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** 173124
No. 695211022695 St. Registration District No. 99 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 2122 Local Registrar's No. 961

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>12</u>	Legitimate? <u>yes</u>	Date of birth <u>July 11, 1929</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Stied Ben

Number of child of this mother, including present birth 12 (a) Born alive and now living 6

Born alive but now dead 6 Stillborn 2

FATHER FULL NAME <u>Oscar Ward Winters</u>	MOTHER FULL MAIDEN NAME <u>Jennie E. Winters</u>
---	---

Residence (Usual place of abode) <u>Chester</u>	Residence (Usual place of abode) <u>Chester</u>
---	---

If nonresident, give place and State _____	If nonresident, give place and State _____
--	--

Color or race <u>W.</u> Age at last Birthday <u>41</u>	Color or race <u>W.</u> Age at last Birthday <u>39</u>
	(Years)

Birthplace <u>Sanpete Co., Utah</u>	Birthplace <u>Weber Co., Utah</u>
(City and State or Country)	(City and State or Country)

Occupation <u>Farmer</u>	Occupation <u>Wife</u>
--------------------------	------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

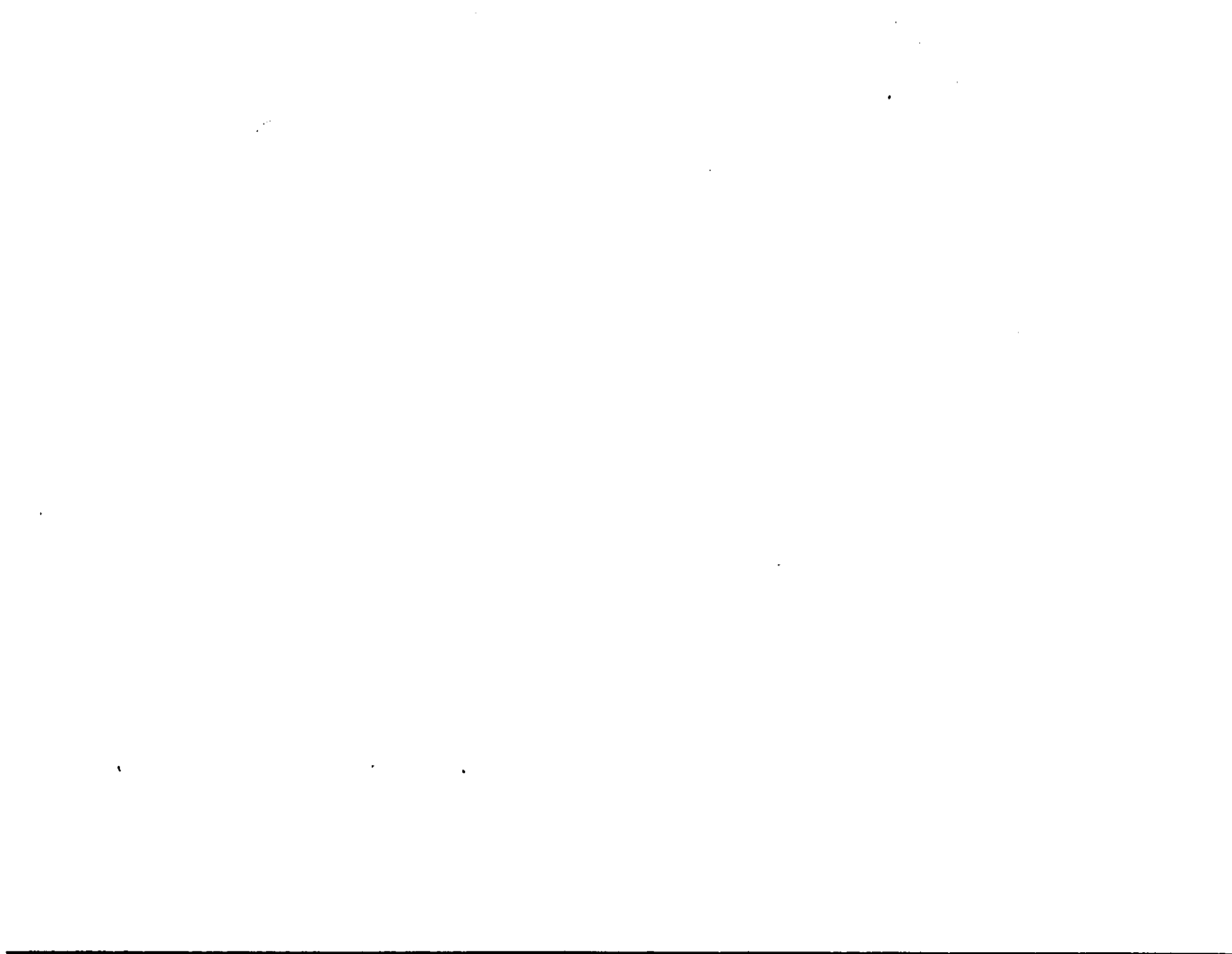
I hereby certify that I attended the birth of this child, who was Born alive at 7:30 A. M.
on the date above stated. Stillborn

(Signature) P. M. Kelly, M.D.
Premature & few days dead.
(Physician or midwife)

Address St. Anthony, Ida.

Filed 7/26 1929 W. H. Hansen
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED AUG 3 1929** STATE OF IDAHO
County of gem DEPARTMENT OF PUBLIC WELFARE
City of Emmett BUREAU OF VITAL STATISTICS
No. 796-131 023 315 CERTIFICATE OF BIRTH **S 173210**
(If born in hospital or institution
give name.) Registration District No. 6 State File No. 173210
Prim. Registration District No. Still born Local Registrar's No. Still born
FULL NAME OF CHILD Still born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 31</u> (Month) (Day) (Year) <u>1929</u>
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 8 (a) Born alive and now living 5
Born alive but now dead 2 Stillborn and

FATHER FULL NAME <u>Dr. Wallace Snowcock</u>	MOTHER FULL NAME <u>Fay Cline Canning</u>
---	--

Residence (Usual place of abode) Emmett Ida Residence (Usual place of abode) Emmett Ida

If nonresident, give place and State

Color or race White Age at last Birthday 40 (Years) Color or race White Age at last Birthday 37 (Years)

Birthplace Nebraska (City and State or Country) Birthplace Nebraska (City and State or Country)

Occupation San mill work Occupation house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 12 PM on the date above stated.

(Signature) J. H. Reynolds
(Physician or midwife)

Address Emmett Ida

Filed 8-1 1929 J. H. Reynolds Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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RECEIVED AUG 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 66966

PLACE OF DEATH

County of BenCity of EmmettRegistration District No. 6

Primary Registration District No. _____

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Still born infant no name

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)Infant fetus5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of✓

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of worknone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Emmett Ida

10. NAME OF FATHER

Leo Wallace Growcock11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Emmett Ida

12. MAIDEN NAME OF MOTHER

Fay Clire Canning13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Emmett Ida

14.

Informant

(Address)

Leo W GrowcockEmmett Ida

15.

Filed

8-2, 1929J. H. Reynolds

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still born July 31, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth, 19____, to____, 19____

that I last saw him alive on____, 19____

and that death occurred, on the date stated above, at____ m.

The CAUSE OF DEATH* was as follows:

Still born babyDo not know cause
had been dead several days

CONTRIBUTORY

(Secondary)

mother had toxemia
of pregnancy
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

J. H. Reynolds M. D.

19

(Address)

Emmett Ida*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Emmett cemetery 7/31 1928

20. Undertaker

Address

E. J. BucknerEmmett Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 19 1929 STATE OF IDAHO
County of Shoshone DEPARTMENT OF PUBLIC WELFARE
City of Shoshone Idaho BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 751720-032-254 Registration District No. 16 State File No. 173366
(If born in hospital or institution give name.)
Prim. Registration District No. 1010 Local Registrar's No. 18
FULL NAME OF CHILD Robert Shepherd, Sheriff
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <input type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input type="checkbox"/>	Number in order of birth <u>1</u>	Legitimacy <u>Yes</u>	Date of birth <u>June 20 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead None Stillborn

FATHER FULL NAME <u>Raymond H. Pease</u>	MOTHER FULL MAIDEN NAME <u>Pearle Reddes</u>
---	---

Residence (Usual place of abode) Shoshone Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 41 (Years)

Birthplace Idaho (City and State or Country)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Shoshone Idaho on the date above stated.

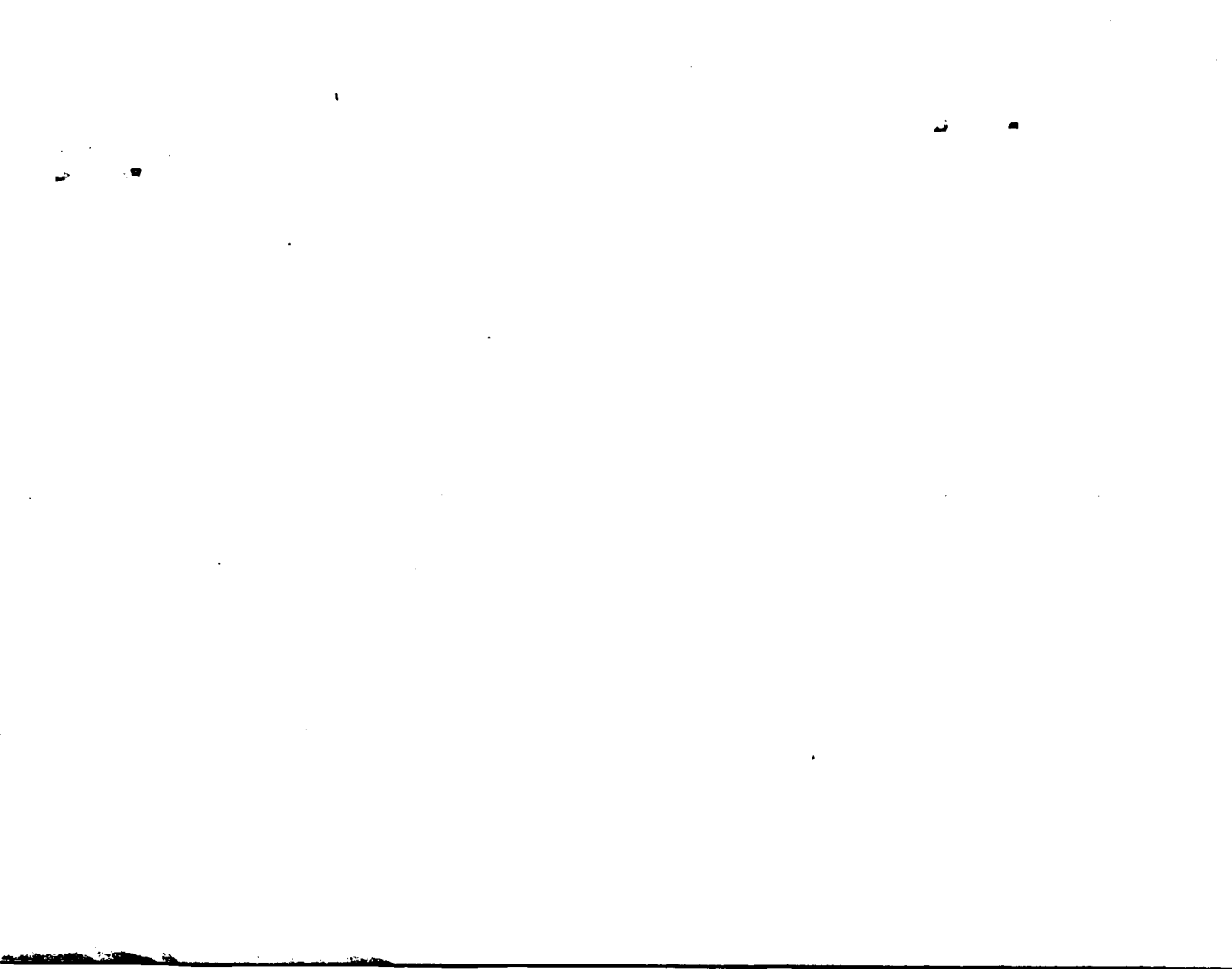
(Signature) Dr. J. H. Miller, M.D.

(Physician or midwife)

Address Shoshone Idaho

Filed June 22 1929 Registrar J. H. Miller

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **67027**

PLACE OF DEATH

County of Lincoln
City of Shoshone

Registration District No.

Primary Registration District No. 416(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15112. FULL NAME Still Born

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20 1929

7. AGE Years Months Days If LESS than 1 day, # hrs. or # min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Shoshone Idaho
(State or country)10. NAME OF FATHER W B Pear11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)12. MAIDEN NAME OF MOTHER Pearl Beddes13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant W B Pear
(Address) Shoshone Ida15. File June 21, 19 29 J L Green
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 20, 1929,
that I last saw him alive on June 20, 1929,
and that death occurred, on the date stated above, at Shoshone m.
The CAUSE OF DEATH* was as follows:
Still Born.

(duration) yrs. mos. ds.
CONTRIBUTORY Premature, 6 1/2 mo.
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Still Born(Signed) J L Green M. D., 19 29 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shoshone Ida Date of Burial 6-21 1929

20. Undertaker W B Pear Address Shoshone Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED IN REPLY JUL 24 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Benewah

City of Lapwai

No. 942-104 035-296 St.

Registration District No. 128

State File No.

173412

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

William Russell

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

Yes

Number
in order
of birth

2

Legiti-
mate?

yes

Date of
birth

April 4

1929

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

Wm. W. Russell

FULL
MAIDEN
NAME

MOTHER

Mabel Brown

RESIDENCE

Lapwai Idaho

RESIDENCE

Lapwai Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

28

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

26

(Years)

BIRTHPLACE

Madara California

BIRTHPLACE

Portland Ore.

OCCUPATION

Electrician

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Geo. O. Steen, M.D.
Physician Lapwai Idaho

(Physician or midwife)

Address

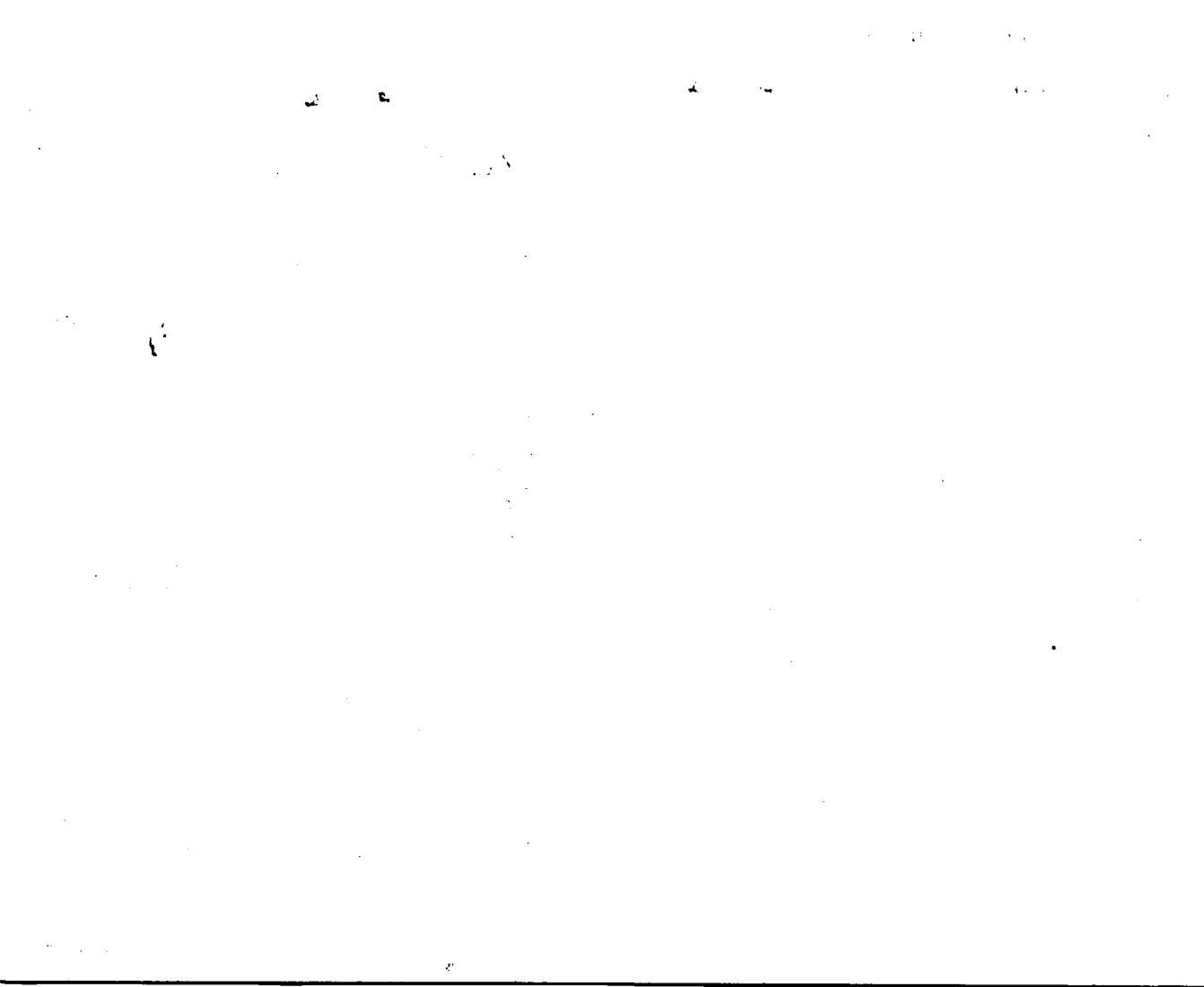
Filed

April

1929

George Gagnier, M.D.
Registrar

Registrar



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. **RECEIVED JUL 24 1929** CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Lapwai
City of Lapwai

Registration District No. 128

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Russell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 67049

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

April 4 1929
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

Lapwai, Idaho.
(State or Country)

10. NAME OF Father

Wm W. Russell

11. BIRTHPLACE OF FATHER

Medora California
(State or Country)

12. MAIDEN NAME OF MOTHER

Mabel Brown

13. BIRTHPLACE OF MOTHER

Portland Oregon
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo O. Keck
(Address) Lapwai, Idaho

15.

Filed April - 1929 Geo. Guignard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 4 1929 to April 4 1929
that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still Born -
(Cause unknown)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo O. Keck M. D.
4/5 1929 (Address) Lapwai, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ days, State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Spalding, Ida.

DATE OF BURIAL

4/6 1929

20. UNDERTAKER

The Family - Lapwai, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168 719 642-355
PLATE OF BIRTH

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

173470

County of Latah

City of Letonia

No. _____ St. _____ Registration District No. 77 State File No. _____

Hospital _____ Primary Registration District No. 9176 Local Registrar's No. 3

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? + Date of birth 7/19 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Balsol - 10%

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Carl W. Johnson
RESIDENCE Letonia
COLOR W AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Utah
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Helen Letonia
RESIDENCE Do
COLOR Do AGE AT LAST BIRTHDAY 26
(Years)
BIRTHPLACE Ida.
OCCUPATION School teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

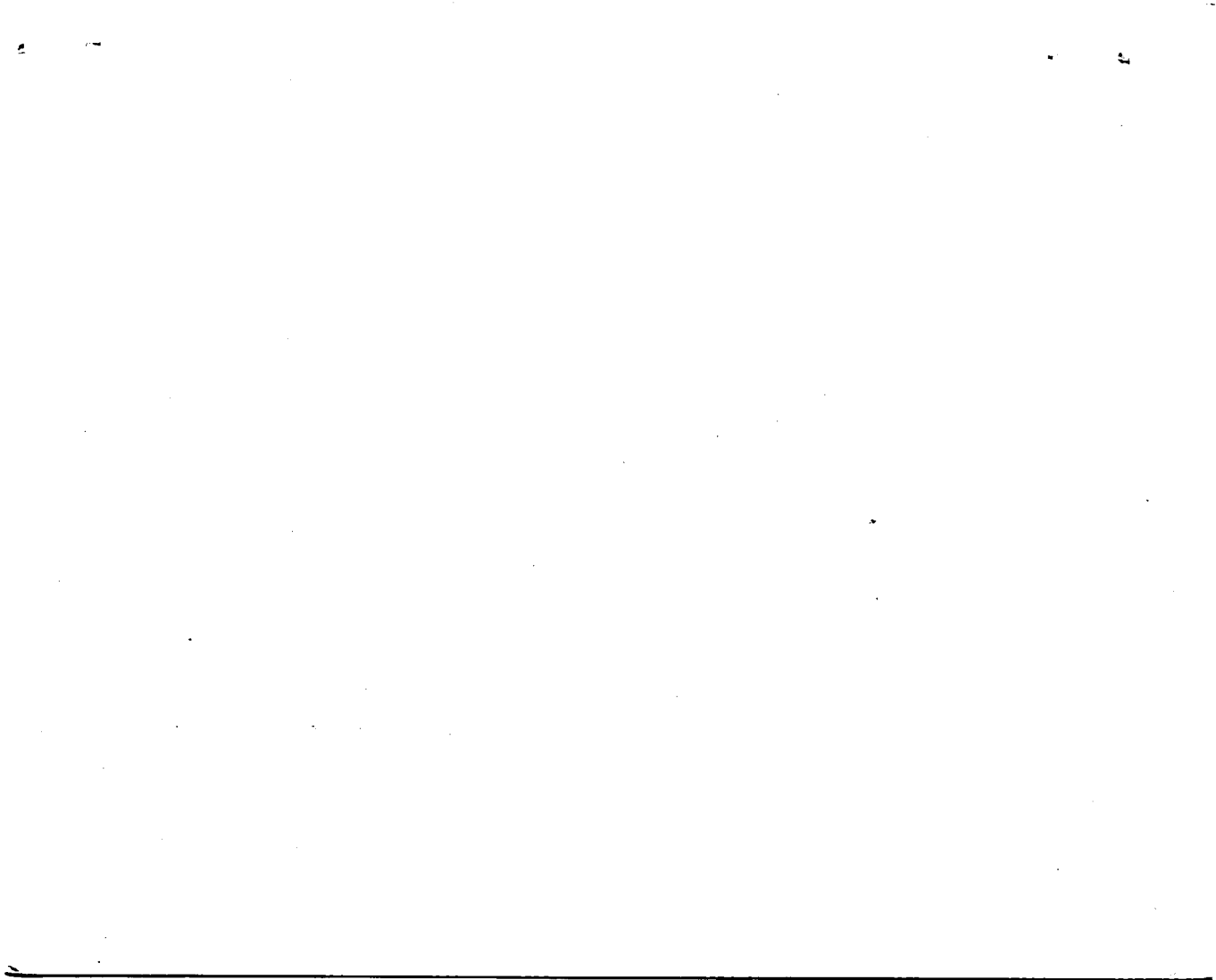
I hereby certify that I attended the birth of this child, who was Stillborn at 140 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192

Dr. L. T. Pedersen, M.D.
(Signature) _____
(Physician or midwife)

Address Triggs, Idaho

Filed 7-30-1929 Martha Marker
Registrar. Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 87096

County of Teton
City of Teton R.D.

Registration District No.

Primary Registration District No.

Local Registrar's No. 25

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stell Benti

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND or
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19-1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Teton R.D.
(State or country) Idaho

10. NAME OF FATHER Carl Wm Johnson

11. BIRTHPLACE OF FATHER (city or town) Huntsville
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Helen Letham

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant D. B. Letham
(Address) Teton Idaho

15. Filed 7-29-1929 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Stell Benti
Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY 7 months pregnancy
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) R. T. C. Jones, M. D.
7/20, 1929 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Date of Burial 7-20-1929

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

173580

County of Ada
City of Barber Idaho
No. _____ St. _____

Registration District No. _____ State File No. _____

236-116 001-742
(If born in hospital or institution
give name.)

Prim. Registration District No. _____ Local Registrar's No. 61

Baby died in stomach 10 days before conf.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child Male

Twin
Triplet
or other? } and { Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? yes

Date of
Birth

Aug 16 19 29
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn one

FATHER

FULL
NAME Sam A. Bloomstrand

Residence (Usual place of abode) Barber

If nonresident, give place and State Idaho

Color or race W Age at last Birthday 61
(Years)

Birthplace Sweden
(City and State or Country)

Occupation Laborer

MOTHER

FULL
MAIDEN
NAME Anna M. Gustafson

Residence (Usual place of abode) Boise

If nonresident, give place and State Idaho

Color or race W Age at last Birthday 41
(Years)

Birthplace Sweden
(City and State or Country)

Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn } at 2-15 A.M. M.
on the date above stated.

(Signature) John Bowk

(Physician or midwife)

Address Boise Idaho

Filed 8-24-1929 W. N. Rhodes

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

279 212 001 '363

PLACE OF BIRTH

County of Boone
City of Boone

No. St. Luke's St.

(If born in hospital or institution give name.)

RECEIVED SEP 6 - 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 2 State File No. 173609

Prim. Registration District No. 1004 Local Registrar's No. 350

FULL NAME OF CHILD Mary Elizabeth Sproat
(If stillborn substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Aug 12</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Wm Dalrymple Renewich Sproat
Residence (Usual place of abode) Boone Ida
If nonresident, give place and State
Color or race wh Age at last Birthday 38 (Years)
Birthplace Scotland (City and State or Country)
Occupation Mechanic

MOTHER
FULL MAIDEN NAME Vera Collins
Residence (Usual place of abode) Boone Ida
If nonresident, give place and State
Color or race wh Age at last Birthday 27 (Years)
Birthplace Montevista Colo (City and State or Country)
Occupation Housewife

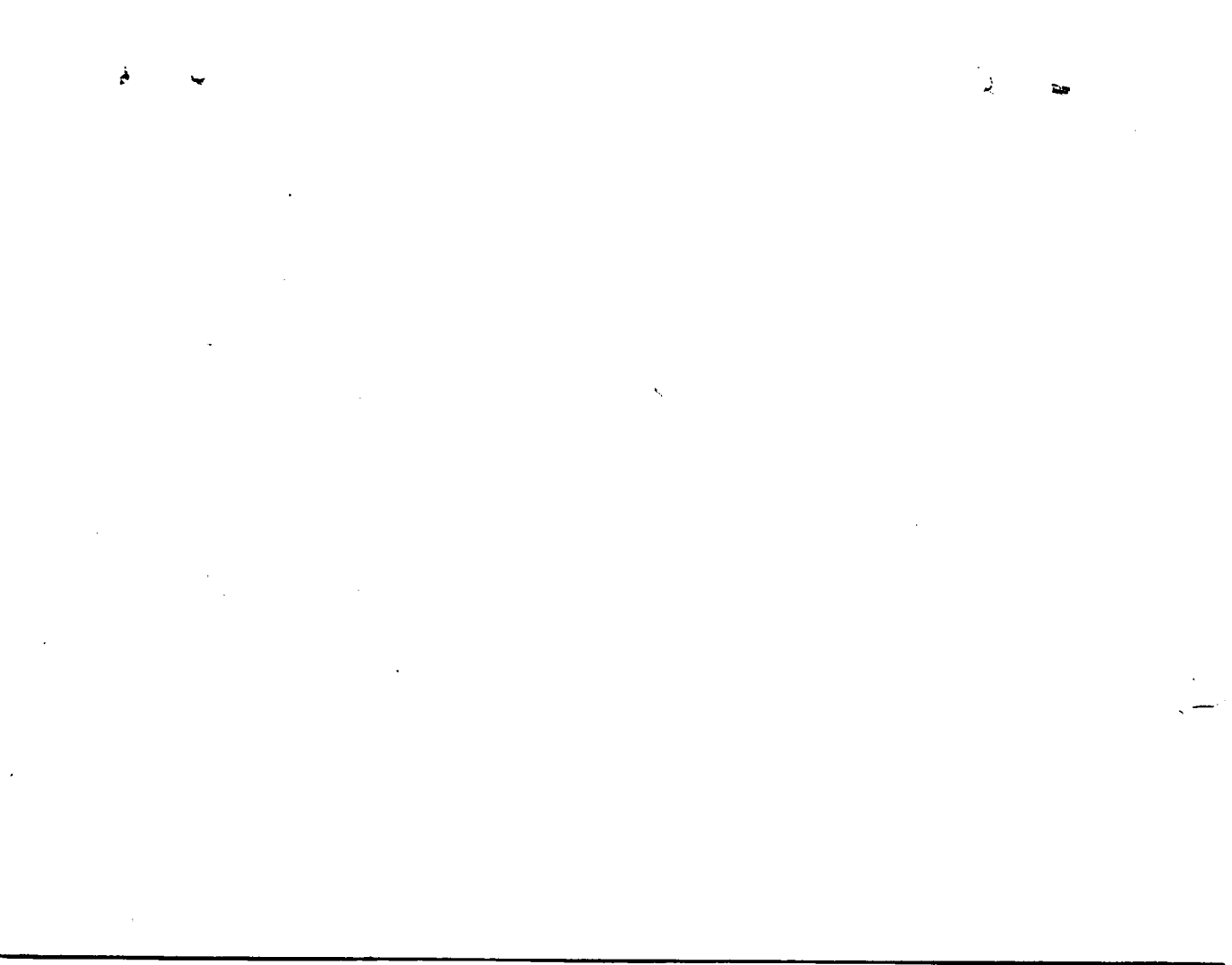
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10:40 P.M. M. on the date above stated.

(Signature) J. R. Numbert (by J. R. Numbert)
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Boone Ida
Filed 8-15-1929 W. H. Rhodes
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67121

Local Registrar's No. 212

2. FULL NAME Mary Elisabeth Sproat.

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female.

4. COLOR OR RACE

White.

5. Single, Married, Widowed,
or Divorced (write the word)

Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 12th 1929

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.

0

0

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

None.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

Rex Sproat.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Scotland.

12. MAIDEN NAME OF MOTHER

Vera Collins.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Monte Vista, Colo.

14. Informant Rex Sproat.

(Address)

Boise, Idaho.

15. Filed 8-13, 1929

W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 12th 1929

(Month)

(Day)

19____
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Sties born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis _____

(Signed) Joseph R. Chambers M. D.

8/13/29, 19____ (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial Wampa, Idaho

Date of Burial

Khelerlawn Cemetery.

8/14/29

19____

20. Undertaker

Address

Wm. McBratney/

Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Group"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of BlaineCity of Fish HavenNo. 469122004168 St. (If born in hospital or institution
give name.)Registration District No. 55State File No. 2173669Prim Registration District No. Stillborn Local Registrar's No. FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child MaleTwin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birthLegiti-
mate YesDate of
birth Aug 22

(Month)

(Day)

1929
(Year)What prophylactic was used to prevent Ophthalmia Neonatorum? Number of child of this mother, including present birth 4(a) Born alive and now living 2Born alive but now dead 0Stillborn 2FULL
NAME Helvin Mortensen

FATHER

Residence (Usual place of abode) Fish HavenIf nonresident, give place and State Color or race WhiteAge at last Birthday 31

(Years)

Birthplace Idaho

(City and State or Country)

Occupation FarmerFULL
MAIDEN
NAME J. Elmina Johnston

MOTHER

Residence (Usual place of abode) Fish HavenIf nonresident, give place and State Color or race WhiteAge at last Birthday 32

(Years)

Birthplace Idaho

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn
on the date above stated.Defunctive
Stillbornat 345 P. M.(Signature) Stillborn(Physician or midwife) Pares Idaho

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Filed Sept 14 192919 Macey
State Registrar.

NO
D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Received Aug 24-1927 STATE OF IDAHO
County of Bonneville
City of Idaho Falls, Idaho.
No. 468 20300-468 St.
L. D. J. Hospital Registration District No. 73 State File No. S 173776
(If born in hospital or institution give name.)
Prim. Registration District No. 2150 Local Registrar's No. 304

FULL NAME OF CHILD Stillborn. Moyer,
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and {	Number in order of birth <u>1</u>	Legitimate? <u>No</u>	Date of birth <u>July 3, 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME <u>Alberta Moyer,</u>
Residence (Usual place of abode)	Residence (Usual place of abode) <u>Ucon, Idaho.</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race	Color or race <u>white</u>
Age at last Birthday (Years)	Age at last Birthday <u>18</u>
Birthplace (City and State or Country)	Birthplace <u>Ucon, Idaho.</u> (City and State or Country)
Occupation	Occupation <u>House girl</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:50 P. M.
on the date above stated.

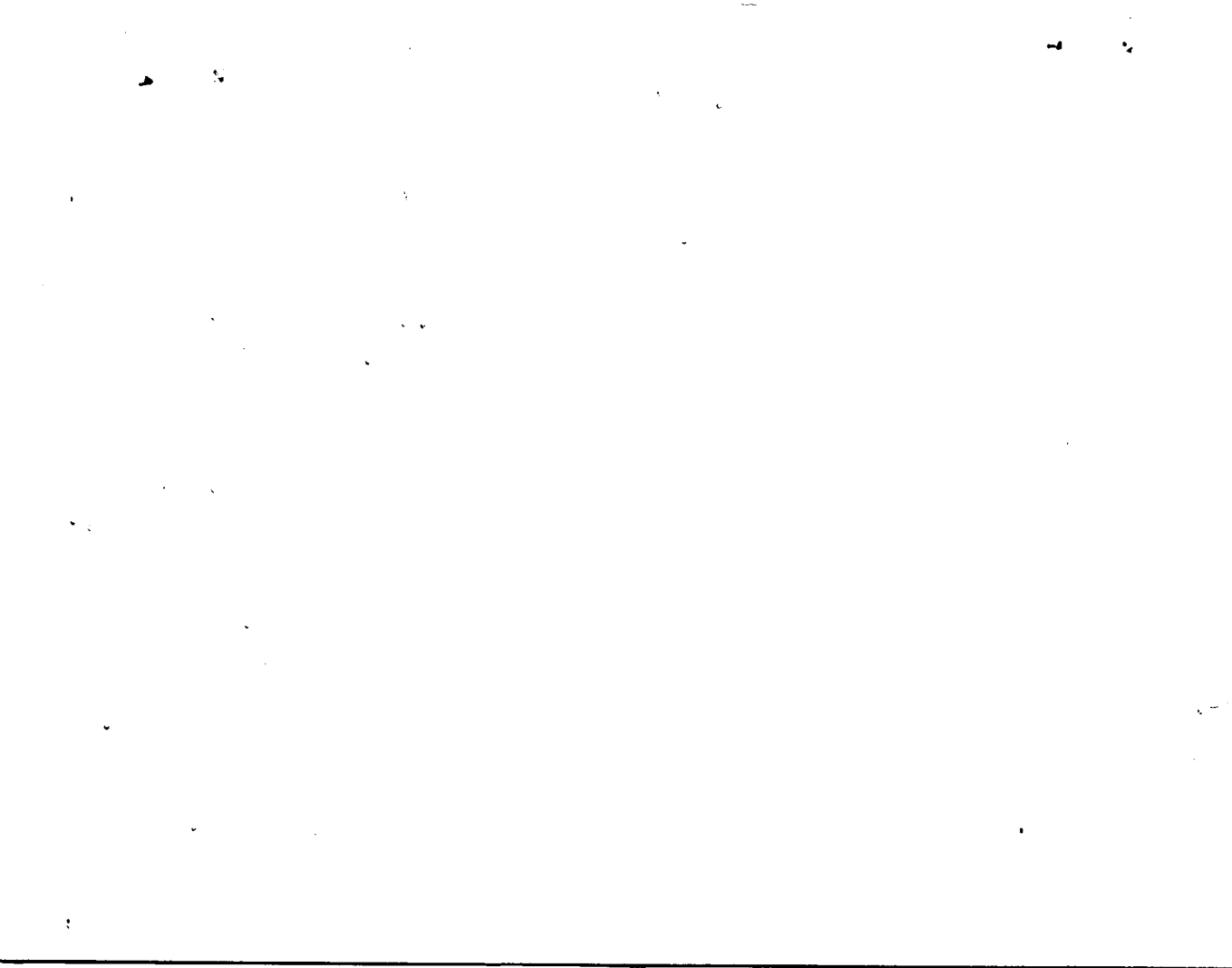
(Signature) Dr. J. J. West

Idaho Falls, Idaho
(City and State or Country)

Address

Filed July 14 - 1929 W. J. West
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. **RECEIVED JUL 9 1929** **CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-0
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 66507
Local Registrar's No. 127

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

July 3 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?
Still born

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

?

(State or Country)

12. MAIDEN NAME OF MOTHER

Alberta Moyer

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. E. Cady

(Address) Idaho

15.

Filed July 11

1929

Local Registrar E. J. ...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/3 1929 to 7/3 1929, that I last saw him alive on 7/3 1929, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta

(Duration) yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. 7 mos. 7 ds.

(Signed)

7/3 1929 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1/2 yrs. 1/2 mos. 1/2 days. In the State 1/2 yrs. 1/2 mos. 1/2 ds.
Where was disease contracted if not at place of death?

Former or usual residence

Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED** AUG 24 1929
County of Benewah STATE OF IDAHO
City of Idaho Falls DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
No. 2125 CERTIFICATE OF BIRTH **S** 173788
547-106-010-595 Registration District No. 73 State File No. 173788
(If born in hospital or institution give name.)
Prim. Registration District No. 7150 Local Registrar's No. 299
FULL NAME OF CHILD Bobby Roy Empey
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>7</u> <u>6</u> <u>1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Crysal

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead _____ Stillborn 1

FATHER	MOTHER
FULL MAIDEN NAME <u>Agnes E. Empey</u>	FULL MAIDEN NAME <u>Bobby M. Nielson Empey</u>
Residence (Usual place of abode) <u>Ammon Idaho</u>	Residence (Usual place of abode) <u>Ammon Idaho</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>W</u> Age at last Birthday <u>37</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>34</u> (Years)
Birthplace <u>Ammon Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was (Stillborn) (at) 5:55 P. M. on the date above stated.

(Signature) John O. Mellar M.D.

(Physician or midwife)

Address Idaho Falls, Idaho

Filed July 14 1929 27 C. J. Mellar
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

c

. 1



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED AUG 12 1929

STATE OF IDAHO

County of Bonner

DEPARTMENT OF PUBLIC WELFARE

S

City of Bonner Ferry

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 493-203-611-469 St. 469

Registration District No. 79 State File No. 173874

(If born in hospital or institution give name.)

Prim. Registration District No. 2156 Local Registrar's No. 7

FULL NAME OF CHILD

Baby Billy - Stillbirth.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>✓</u>	and	Number in order of birth <u>✓</u>	Legitimate? <u>yes</u>	Date of birth <u>Feb. 3 W. 1929</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Jackson B. Shilley

MOTHER
FULL MAIDEN NAME Leona Dorn

Residence (Usual place of abode) Laples, Ida.

Residence (Usual place of abode) Laples, Ida.

If nonresident, give place and State

If nonresident, give place and State

Color or race white Age at last Birthday 32 (Years)

Color or race white Age at last Birthday 19 (Years)

Birthplace Spokane, Wn.
(City and State or Country)

Birthplace Spokane, Wn.
(City and State or Country)

Occupation Woodsman

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 5:15 P. M. on the date above stated. { Stillborn }

(Signature) S. E. Fry

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Bonner Ferry, Ida.

Filed 3/4/1929 S. E. Fry

RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67235

PLACE OF DEATH

County of BoundaryCity of Bonner FerryRegistration District No. 29Primary Registration District No. 2126

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Miller(a) Residence. No. _____ St. 706

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Feb. 3 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Bonner Ferry, Ida.
(State or country)10. NAME OF FATHER Jackson R. Miller11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Spokane, WA12. MAIDEN NAME OF MOTHER Ernesta Dorn13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Spokane, WA14. Informant J. R. Miller
(Address) Bonner Ferry, Ida.15. Filed 2/3/1929
J.R. Miller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Phillborn
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Placental Disease (fibrosis)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J.R. Miller, M. D.2/3/1929 (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Bonner Ferry, Ida. Feb. 3 1929

20. Undertaker Address

J.R. Miller Bonner Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Caldwell

No. 796-219014-213 St.

(If born in hospital or institution
give name.)

Registration District No. 3 State File No. 173896

Prim. Registration District No. 2005 Local Registrar's No. 134

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>July 19 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Elmer B. Gifford</u>	MOTHER FULL MAIDEN NAME <u>Dora E. (Bachelor)</u>
---	--

Residence (Usual place of abode) Reynolds Id.

If nonresident, give place and State

Color or race W Age at last Birthday 33 (Years)

Birthplace Wilson Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born live } at Reynolds Id.
on the date above stated.

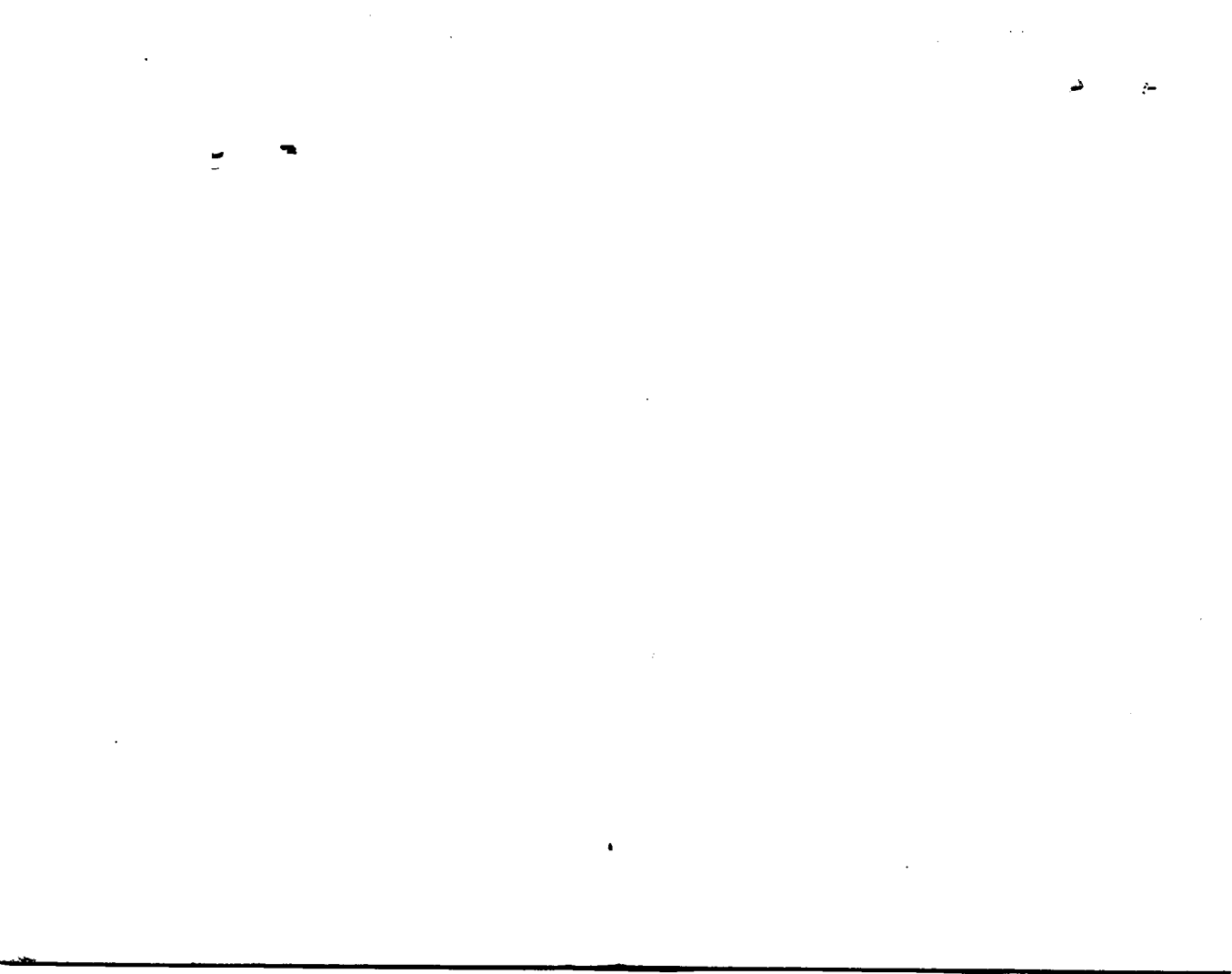
(Signature) David E. Baird

(Physician or midwife)

Address Caldwell Idaho

Filed 7-20-1929 John S. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED AUG 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67258

PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 72

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Clifford
(a) Residence. No. 514 Everett St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 19-29
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address)

15. Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

July 19-1929
that I last saw her alive on No.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Stillborn.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Indefinite
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical
(Signed) David E. Baird, M. D.
July 19, 1929. (Address) Caldwell.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

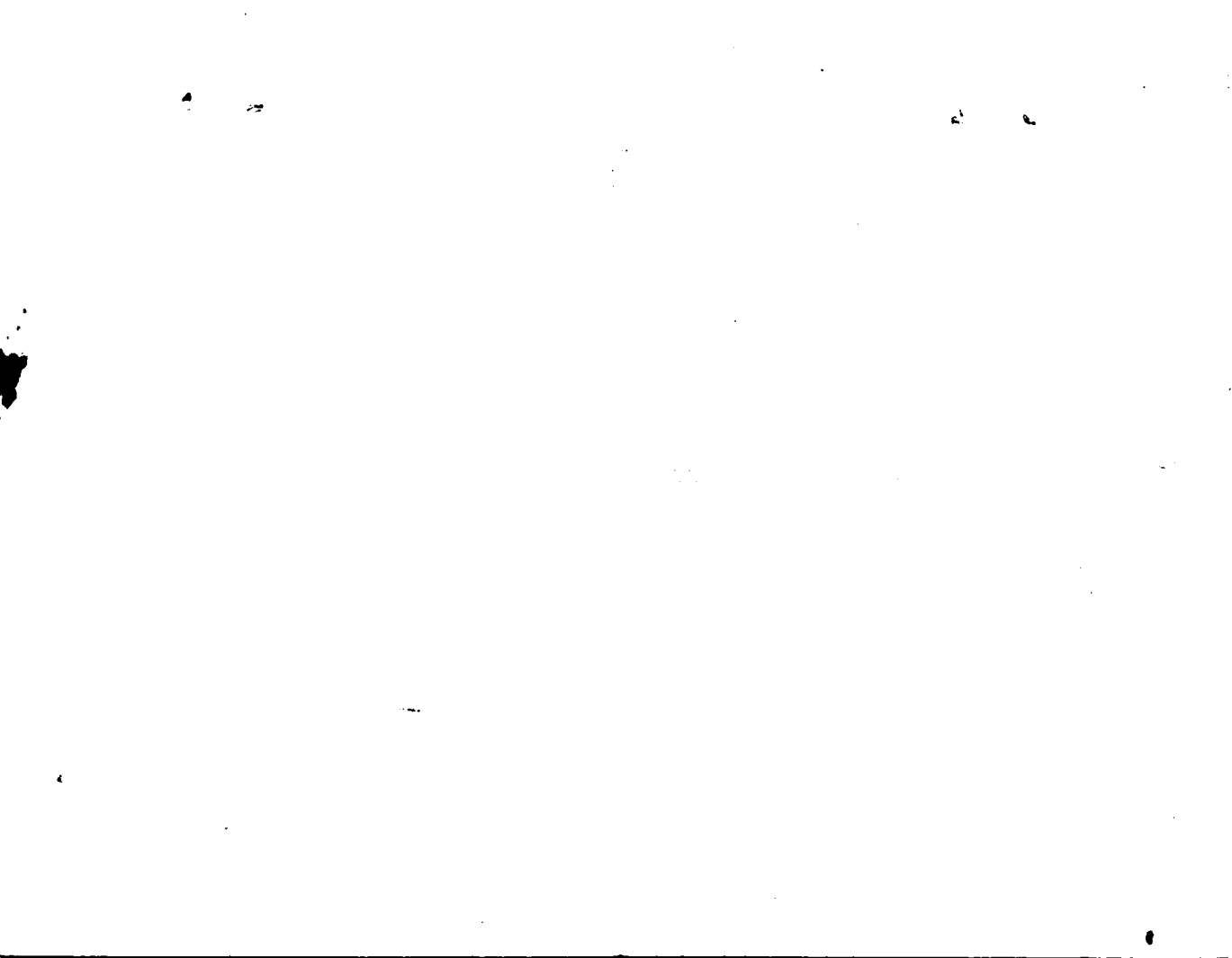
Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

493119 014 769
PLACE OF BIRTH
COUNTY OF IDAHO RECEIVED SEP 10 1929
CITY OF Naupaka
No. mercy St. _____
Registration District No. 7 State File No. 173964
(If born in hospital or institution give name.)
Prim. Registration District No. 1006 Local Registrar's No. 205
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child M- Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth 3-19 1929
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth 1 (a) Born alive and now living _____
Born alive but now dead _____ Stillborn _____
FULL NAME Lloyd Lee Milliken FATHER FULL MAIDEN NAME Golden Jordan MOTHER
Residence (Usual place of abode) Caldwell R#4 Residence (Usual place of abode) Caldwell R#4
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race white Age at last Birthday 23 Color or race white Age at last Birthday 19
(Years) (Years)
Birthplace mo. Birthplace mo.
(City and State or Country) (City and State or Country)
Occupation laborer Occupation housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was Stillborn at 2:45 A. M.
on the date above stated. (Signature) V. E. Bellman
Naupaka, Idaho
(Physician or Midwife)
Address _____
Filed 9 9 1929 W. H. Conner
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **65278**

County of Canyon
City of Nampa

Registration District No.
Primary Registration District No.
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Miller
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>		
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of				
6. DATE OF BIRTH (month, day and year) <u>March 19-1929</u>				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				
9. BIRTHPLACE (city or town) (State or country)				
10. NAME OF FATHER <u>Robert Lee Miller</u> <u>Robert L. Miller</u>				
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Kansas</u>				
12. MAIDEN NAME OF MOTHER <u>Golden Jordan</u>				
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Missouri</u>				
14. Informant <u>Robert L. Miller</u> (Address) <u>Nampa, Idaho</u>				
15. Filled _____, 19____ Registrar				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>March 19th</u> 19 <u>29</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h. _____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still born</u> <u>6 months (Result of</u> <u>Accident)</u> (duration) _____ yrs. _____ mos. _____ ds.	
CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.	
18. Where was disease contracted if not at place of death? Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? (Signed) <u>J. C. Beffert</u> M. D. <u>3-19-29</u> (Address) <u>Nampa, Ida</u>	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation, or Removal <u>Kohlerlawn-Nampa</u>	Date of Burial <u>3-19-1929</u>
20. Undertaker <u>Wm D. Talley</u>	Address <u>Nampa, Ida.</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

851-1213-218-719
RECEIVED SEP 7 1929

County of Clearwater
City of Orofino

No. _____ St. _____

Orofino Hospital
(If born in hospital or institution
give name.)

Registration District No. 90 State File No. S174014

Prim. Registration District No. 2187 Local Registrar's No. 55

FULL NAME OF CHILD not named Myrtle Agness Heagy
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Aug</u> <u>19</u> <u>19</u> (Month) (Day) (Year)
----------------------------	---	-------	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Chas C. Heagy

Residence (Usual place of abode) Orofino

If nonresident, give place and State _____

Color or race White Age at last Birthday 30
(Years)

Birthplace Iowa
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Myrtle Robson

Residence (Usual place of abode) Orofino

If nonresident, give place and State _____

Color or race White Age at last Birthday 28
(Years)

Birthplace Iowa
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ 7 P M.
on the date above stated.

(Signature) Om Husted

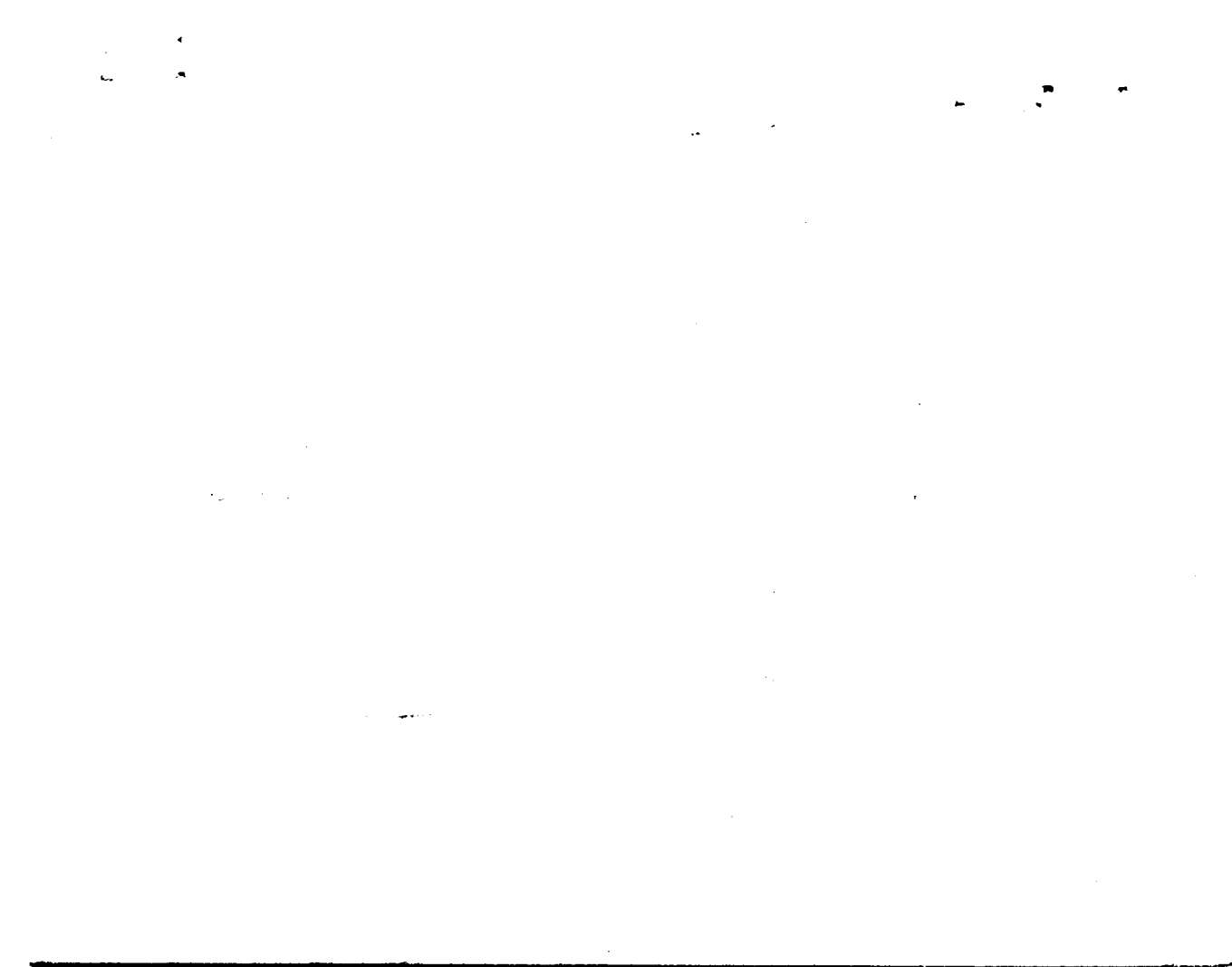
(Physician or midwife)

Address _____

Filed Aug 15 1929 W. A. Shaw

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **67285**

PLACE OF DEATH

County of ClearwaterCity of OrfinsRegistration District No. 90Primary Registration District No. 2187Local Registrar's No. 92

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby not named(a) Residence. No. Orfins Hospital St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 13 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Orfins Ida
(State or country)10. NAME OF FATHER C.E. Heagy11. BIRTHPLACE OF FATHER (city or town) Iowa
(State or Country)12. MAIDEN NAME OF MOTHER Mortal Person13. BIRTHPLACE OF MOTHER (city or town) Ida
(State or Country)14. Informant C.E. Heagy
(Address) Orfins15. Filed Aug 14 1929 V.H. Haas
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 13 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 13 1929, to Aug 13 1929
that I last saw him alive on

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? ✓Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.
Aug 14 1929 (Address) Orfins Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Central Ring7/15- 1929

20. Undertaker

Address

V.H. HaasOrfins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED OCT 14 1929

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT.
SEP 21 1929

Boise, Idaho

174014

Mrs. Chas. C. Heagy

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Orofino, Idaho

Dear Madam:-

IDaho is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Myrtle Agnes Heagy

PLACE OF BIRTH *Orofino*

DATE OF BIRTH

Aug. 13,

SEX OF CHILD

Female

1. Number of children born to this mother, including present birth *Three*
2. Number born alive and now living *Two*
3. Born alive but now dead *None*
4. Number of children stillborn *None*

(Please write plainly)

Information with reference to
FATHER

Charles Everett Heagy
(Full name)

Orofino Idaho
(Residence)

Age at last birthday *38*

Monterido Minn
(Birthplace)

Farmer
(Occupation)

Information with reference to
MOTHER

Miss Myrtle Agnes Pa.
(Full Maiden name)

Orofino Idaho
(Residence)

Age at last birthday *28*

Hendrick Idaho
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C. K. Macey,

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 12 1929

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 171023

County of Elmore

City of Mtn Home

No. _____ St. _____

464 116 020-249

(If born in hospital or institution
give name.)

Registration District No. 34

State File No. _____

Prim. Registration District No. 2020

Local Registrar's No. 16

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legiti-mat-er <u>yes</u>	Date of birth <u>June 16</u> 192 <u>9</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Frank Dodge

Residence (Usual place of abode) Mtn Home Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 22 (Years)

Birthplace Brunnman Idaho (City and State or Country)

Occupation Trucking

MOTHER
FULL MAIDEN NAME Eleanor Burnett

Residence (Usual place of abode) Mtn Home Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 18 (Years)

Birthplace Hill City Ida (City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:30 A. M. on the date above stated. { Stillborn }

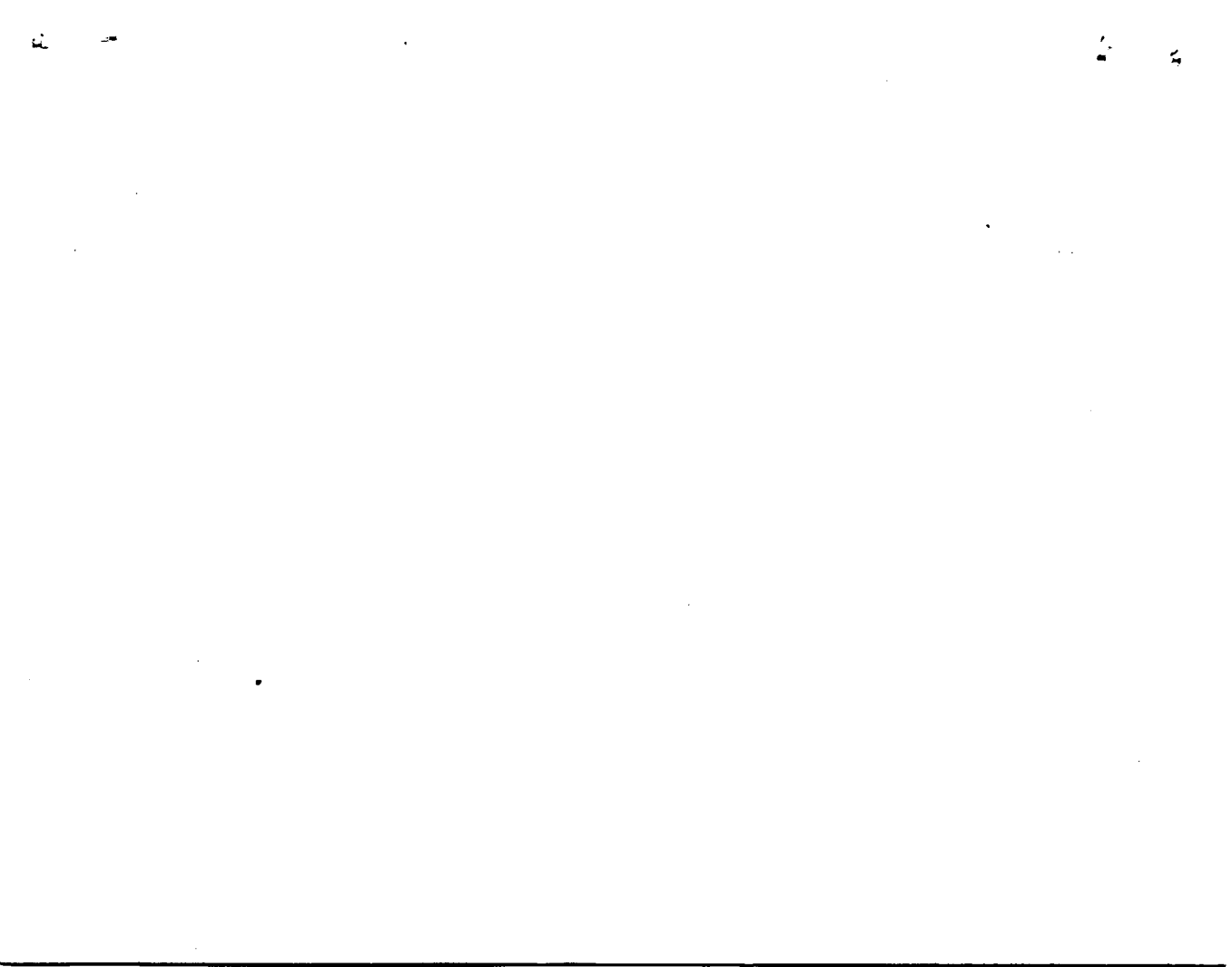
(Signature) J. E. Brown

M.D.
(Physician or midwife)

Address Mtn Home, Ida.

Filed Aug 9 1929 M. D. Anderson
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 12 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ElmoreCity of Butte Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34Primary Registration District No. 2820

(No. _____ St.)

File No. 66565Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Dodge, (infant)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 71 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 16 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

_____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

F. Dodge

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Burnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. Dodge(Address) Butte Home Idaho15. Filed July 2, 1929 A. H. Anderson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-16-1929, to 6-16-1929

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Evans M. D.6-20-1929 (Address) Butte Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Butte Home

DATE OF BURIAL

6-17-1929

20. UNDERTAKER

J. S. Zacher

ADDRESS

Butte Home

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED SEP 6 - 1929

County of Elmore
City of Glenis Ferry
No. _____ St. _____

245-226 000-418
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 35 State File No. 174028
Prim Registration District No. 2021 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug 26</u> <u>1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead none Stillborn one

FATHER	MOTHER
FULL NAME <u>Chas R. Borders</u>	FULL MAIDEN NAME <u>Edna Day</u>
Residence (Usual place of abode) <u>Glenis Ferry Ida</u>	Residence (Usual place of abode) <u>Glenis Ferry</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>22</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>18</u> (Years)
Birthplace <u>Montana</u> (City and State or Country)	Birthplace <u>California</u> (City and State or Country)
Occupation <u>Switchman R.R.</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 230 a M.
on the date above stated. (Signature) Dr. J. W. Davis M.D.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Glenis Ferry Idaho
Filed 8-29 1929 Mrs Mary Sullivan
Registrar.

THIS IS A CERTIFICATE OF BIRTH
 IN THE STATE OF ILLINOIS
 COUNTY OF COOK
 CITY OF CHICAGO
 I hereby certify that I attended the birth of this child who was born on the date above stated.

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

On the date above stated.

I hereby certify that I attended the birth of this child, who was (Stillborn) (Born alive) at (Chicago) (at)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Residence (City and State of Country) (City and State of Country) Occupation

It is recommended, give place and date (Age at last birthday (Years)

It is recommended, give place and date (Age at last birthday (Years)

Residence (Last place of residence)

NAME (MOTHER) (FATHER)

It is recommended, give place and date (Age at last birthday (Years)

It is recommended, give place and date (Age at last birthday (Years)

What prophylactic was used to prevent Ophthalmia neonatorum?

Child (Sex of child) (Date of birth) (Time of birth) (Place of birth) (Manner of birth)

It is recommended, give place and date (Age at last birthday (Years)

It is recommended, give place and date (Age at last birthday (Years)

It is recommended, give place and date (Age at last birthday (Years)

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It is recommended, give place and date (Age at last birthday (Years)

It is recommended, give place and date (Age at last birthday (Years)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 - 1929

PLACE OF DEATH

County of ElmoreCity of Glenns FerrySTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 35Primary Registration District No. 2021

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white5. Single Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year)

August 26 - 1929

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Glenns Ferry Idaho

10. NAME OF FATHER

Chas. R. Bowden11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Montana

12. MAIDEN NAME OF MOTHER

Edna Day13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)California

14. Informant

Chas R. Bowden
(Address) Glenns Ferry Idaho

15. Filed

8-29, 1929 Mr. Mary Lubman

DO NOT WRITE IN THIS SPACE

State File No. 67294

Local Registrar's No. _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 26, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 25, 1929, to Aug. 26, 1929that I last saw her alive on Aug. 25, 1929and that death occurred, on the date stated above, at 230 a.m.

The CAUSE OF DEATH* was as follows:

Still born.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. W. Davis, M. D.Aug. 29, 1929 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Glenns Ferry Ida 8-29, 1929

20. Undertaker

Address

C. R. Bowden Glenns Ferry Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH SEP 6 - 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174031

County of Elmore
City of Glenns Ferry

No. _____ St. _____

697127020-295

(If born in hospital or institution give name.)

Registration District No. 35 State File No. _____

Prim. Registration District No. 2021 Local Registrar's No. _____

FULL NAME OF CHILD Baby Wilson (Stillborn)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- macy <u>Yes</u>	Date of birth <u>Aug 27</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead 3 Stillborn 3

FATHER	MOTHER
FULL NAME <u>Sim Wilson</u>	FULL MAIDEN NAME <u>Pearl King</u>

Residence (Usual place of abode) Glenns Ferry

If nonresident, give place and State. _____

Color or race white Age at last Birthday 29 (Years)

Birthplace Livers, Idaho (City and State or Country)

Occupation Laborer

Residence (Usual place of abode) Glenns Ferry

If nonresident, give place and State. _____

Color or race white Age at last Birthday 26 (Years)

Birthplace Sparron Lake (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 P. M. on the date above stated.

(Signature) M. J. Tuendeling M.D.

Physician
(Physician or midwife)

Address Glenns Ferry Idaho

Filed 8-28 1929 Mrs. Mary Sullivan
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1

2

3

4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 17202

- PLACE OF DEATH
County of Elmore
City of Glenns Ferry

Registration District No. 35
Primary Registration District No. 2021

Local Registrar's No. 204

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Wixon

(a) Residence. No. Glenns Ferry St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced ---
5a. If married, widowed, or divorced HUSBAND of ---- (or) WIFE of		
6. DATE OF BIRTH (month, day and year) August 27, 1929		
7. AGE 0	Years 0	Months 0
Days 0		If LESS than 1 day, hrs. or min. 0
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. --- (b) General nature of industry, business, or establishment in which employed (or employer) --- (c) Name of employer ---		

Glenns Ferry

9. BIRTHPLACE (city or town) (State or country)
10. NAME OF FATHER Sim Wixon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Livery, Ida
12. MAIDEN NAME OF MOTHER Pearl King
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sharon, Ida

14. Informant Father (Address) Glenns Ferry
--

15. Filed 8-28, 1929 Mrs Mary Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 27, '29 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from --- , 19 <u>29</u> , to --- , 19 <u>29</u> , that I last saw h. --- alive on --- , 19 <u>29</u> , and that death occurred, on the date stated above, at --- m. The CAUSE OF DEATH* was as follows:

STILLBORN

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.
18. Where was disease contracted if not at place of death? _____ Date of _____ Did an operation precede death? _____ Was there an autopsy? No What test confirmed diagnosis? _____ (Signed) <u>M. J. Sullivan</u> Aug 27 , 19 <u>29</u> (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal <u>Glenns Ferry Ida</u>	Date of Burial <u>5-28</u> 19 <u>29</u>
20. Undertaker <u>G. C. Zacher</u>	Address <u>M. H. Homer Ida</u>

APR 1914

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL; or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED ON FILE SEP 14 1929

County of Franklin
City of Duston, Ida
No. _____ St. _____

363115 021 255
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174051

Registration District No. 21 State File No. _____

Prim. Registration District No. 2119 Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 15</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Myron M. Cole
Residence (Usual place of abode) Duston, Ida #3
If nonresident, give place and State _____
Color or race White Age at last Birthday 25
Birthplace Duston, Idaho Route #3 (Years)
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Minnie Benson
Residence (Usual place of abode) Duston, Ida #3
If nonresident, give place and State _____
Color or race White Age at last Birthday 25
Birthplace Western, Ida (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive (Stillborn) (a) 10 20 A. M.
on the date above stated.

(Signature) A. R. Butler
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Duston, Ida
Filed Aug 22 1929 A. R. Butler
Registrar.

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Full name of child _____
 Sex of child _____
 Date of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of informant _____
 Address of informant _____
 Date of registration _____
 Signature of registrar _____

What prophylactic was used to prevent Ophthalmia Neonatorum?
 Name of child of this mother, including present birth _____
 Date of birth _____
 Name of mother _____
 Name of father _____
 Name of informant _____
 Address of informant _____
 Date of registration _____
 Signature of registrar _____

I hereby certify that I attended the birth of this child, who was _____
 of the date above stated.
 Signature of attending physician or midwife _____
 Address of attending physician or midwife _____
 Date of registration _____
 Signature of registrar _____

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither passes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

698-109-028-231

PLACE RECEIVED SEP 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 174127

County of Butte
City of Camden Place
No. 5193 Mount Drive

Registration District No. 30 State File No. _____
Prim. Registration District No. 1020 Local Registrar's No. 142

FULL NAME OF CHILD Stillborn Prymire
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin } and { Number in order of birth Triplet } (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Aug 9 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5th (a) Born alive and now living 2
Born alive but now dead none Stillborn (3)

FATHER
FULL NAME Walter Prymire
Residence (Usual place of abode) _____
If nonresident, give place and State Canada
Color or race white Age at last Birthday 33 (Years)
Birthplace S. S. Wallmont (City and State or Country)
Occupation Farmer

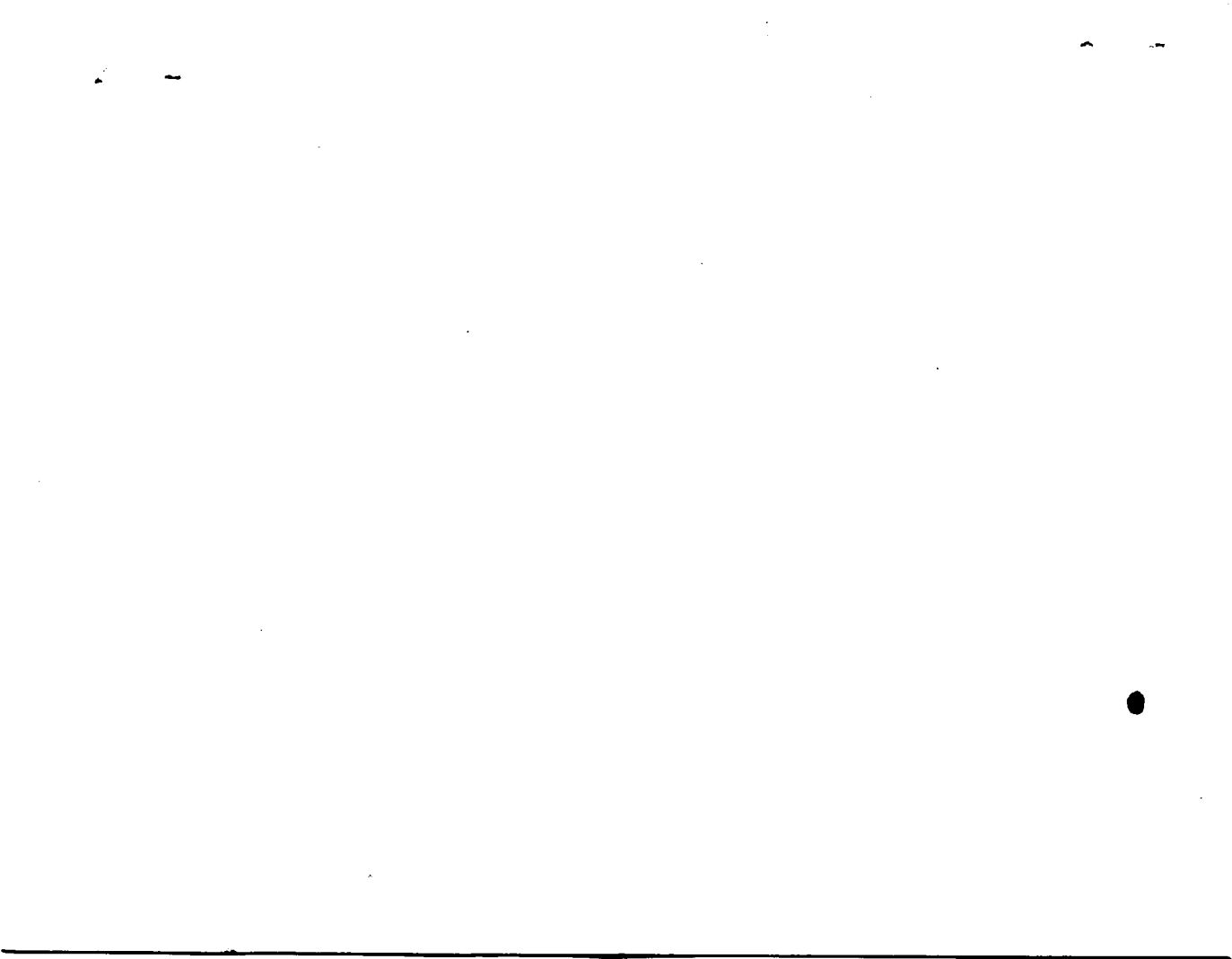
MOTHER
FULL MAIDEN NAME Gladys Stanley
Residence (Usual place of abode) _____
If nonresident, give place and State Canada
Color or race white Age at last Birthday 26 (Years)
Birthplace Minneapolis, Minn. (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 P. M. on the date above stated.
(Signature) L. L. McFarland
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address 210 Harding Bldg. Camden Place
Filed 8/29 1929 H. J. Sturgeon
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED SEP 7 1929

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Montana*
City of *Camden*
If death occurs away from usual residence, give facts called for under special information.

Registration District No. *50*
Primary Registration District No. *1050*
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *67241*
Registered No. *136*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Un-named Frymire*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *Aug 10 1929*
(Month) (Day) (Year)

7. AGE *Still-born* IF LESS than 1 day how many hrs. or min.?
..... Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Camden Idaho*
(State or Country)

10. NAME OF FATHER *Walter Frymire*

11. BIRTHPLACE OF FATHER *South Dakota*
(State or Country)

12. MAIDEN NAME OF MOTHER *Gladys Stanley*

13. BIRTHPLACE OF MOTHER *Missouri*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mary Stanley*
(Address) *Camden, Idaho*

15. Filed 191..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 10 1929*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 10 1929* to *Aug 19 1929*
that I last saw him *Still-born* 191.....
and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:
Still-born
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) *J. L. McCauley* M. D.
(Address) *Camden, Idaho*

State the disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Forest Cem C. D. Alamy* DATE OF BURIAL *Sept. 1929*

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (never omit "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

296-104-102-412
PLACE OF BIRTH RECEIVED AUG 12 1929

County of Twin Falls

City of Twin Falls

No. _____ St.

T. F. Coagan
(If born in hospital or institution
give name.)

Registration District No. 37 State File No. _____

Prim. Registration District No. 222 Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 11</u> (Month) (Day)	<u>1929</u> (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Frank E. Bapen

Residence (Usual place of abode) Kimberley

If nonresident, give place and State _____

Color or race W. Age at last Birthday 27 (Years)

Birthplace Bersheba Tenn.
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Mildred Mahan

Residence (Usual place of abode) Kimberley

If nonresident, give place and State _____

Color or race W. Age at last Birthday 20 (Years)

Birthplace Payette Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Stillborn) at _____ P. M.
on the date above stated.

(Signature) _____

(Physician or Midwife)

Address _____

Filed 8-20 1929 David August Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-19-2008 BY 60322 UCBAW/STP

*Where there was no attending physician, or midwife, then the father, householder, etc. should make this return. A child is one that neither practices nor shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was born on the _____ day of _____, 19____.

(Signature) _____
Address _____
City _____ State _____

CERTIFICATE OF ATTENDING PHYSICIAN

Residence (Usual place of abode) _____
 It now resides, give place and State _____
 Date of year _____ Age at last birthday (Years) _____
 Birthplace (City and State or Country) _____
 Occupation _____

PATERNAL

Number of child of the mother, including present and former _____
 Born alive but now dead _____
 What prophylactic was used to prevent (1) _____ (2) _____

Legitimacy _____ Date of birth _____
 (Month) _____ (Year) _____

STATE OF _____

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
 Birth Registration District No. _____ Local Registration No. _____
 Full Name of Child _____
 Sex of Child _____
 Date of Birth _____
 Legitimacy _____
 (Month) _____ (Year) _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67098

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Twentysalls Registration District No. 37
City of " " Primary Registration District No. 1085 Local Registrar's No. 706
(No. 1085)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 536 3rd No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 4 1929

7 AGE Years Months Days 1 If LESS than day, hrs. or min. 8 0 0 1 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ida
(State or country)

10 NAME OF FATHER Frank E. Brown

11 BIRTHPLACE OF FATHER (city or town) Tenn.
(State or country)

12 MAIDEN NAME OF MOTHER Mildred G. Mahan

13 BIRTHPLACE OF MOTHER (city or town) Ida
(State or country)

14 Informant Frank E. Brown
(Address) 536 3rd No. City.

15 Filed 8/10 1929 H. V. Leite
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-4, 1929, to 7-4, 1929.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Shut down at 8 mas

Cause unknown
(duration) yrs. mos. ds.

CONTRIBUTORY Toxemia of pregnancy
(Secondary) in mother 3
(duration) yrs. mos. ds.

18 Where was disease contracted ✓
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) John R. Coughlin M. D.

7-4 1929 (Address) Twentysalls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twentysalls Date of Burial July 5, 1929

20 Undertaker P. J. Froese Address Twentysalls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174235

County of Twin Falls
City of Twin Falls

No. County St. -

Registration District No. 17 State File No. 174235

(If born in hospital or institution
give name.)
Hospital

Prim. Registration District No. 2-23 Local Registrar's No.

FULL NAME OF CHILD Stillbirth Whitney
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Aug 13</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Glenn Whitney</u>	FULL MAIDEN NAME <u>Mabel Mickelwait</u>

Residence (Usual place of abode) Kimberly, Ida.

If nonresident, give place and State Kimberly, Ida.

Color or race white Age at last Birthday 36 (Years)

Birthplace Lafayette Co. Kansas (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

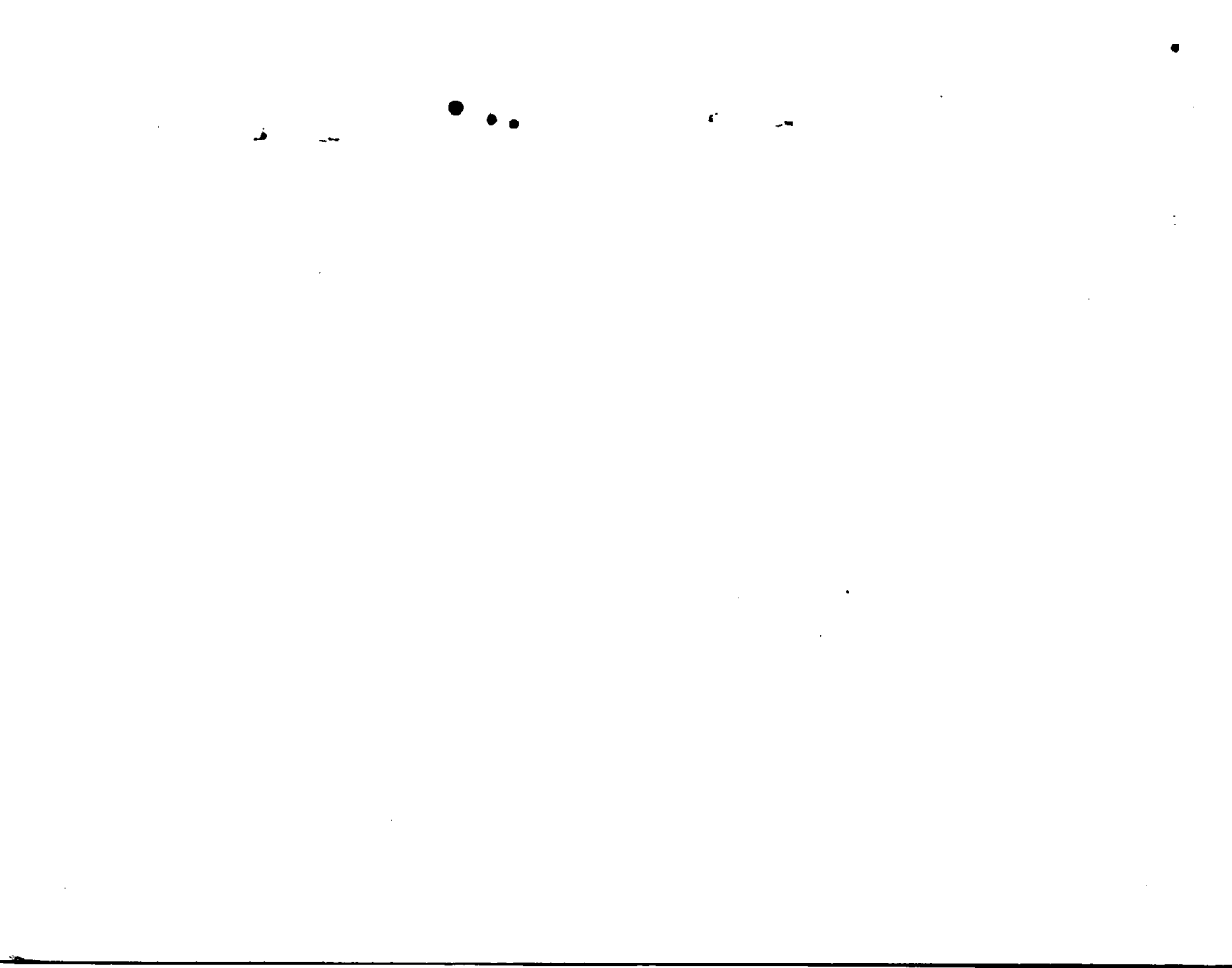
I hereby certify that I attended the birth of this child, who was { Born alive } at 2:15 A. M.
on the date above stated. { Stillborn }

(Signature) J. H. Morgan
Twin Falls, Idaho
(Physician or midwife)

Address Twin Falls, Idaho

Filed 9-1 1929 David M. Cowgill
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67456

PLACE OF DEATH

County of Twin FallsCity of Twin FallsRegistration District No. 37Primary Registration District No. 1033(No. County General Hospital)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Glenn Whitney(a) Residence. No. Kimberly R. F. D. # 2 St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

0 Years

Months

Days 0If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Twin Falls
(State or country)

10 NAME OF FATHER

Glenn Whitney11 BIRTHPLACE OF FATHER (city or town)
(State or country)Kansas

12 MAIDEN NAME OF MOTHER

Nickel Waite13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Iowa14 Informant Glenn Whitney

(Address)

Kimberly, R. F. D. # 2

15

Filed 3-15, 1929David K. Gossman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8
(Month)13
(Day)1929
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at 2 M. m.

The CAUSE OF DEATH* was as follows:

Still bornExistence One week over scheduled9 months (duration) yrs. mos. ds.CONTRIBUTORY Probably Anemia of mother(Secondary) plus twisting of cord to cut offCirculation (duration) yrs. mos. ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? ✓ Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. John R. Morgan, M. D.8/13, 1929 (Address) Twin Falls, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls Cem.Aug. 13 1929

20. Undertaker

Address

P. J. GrossmanTwin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth, and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

356-104,084-395
PLACED IN FILE AUG 20 1929

County of Washington
City of Wenatchee
No. 2 Commercial St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 86 State File No. 174396

(If born in hospital or institution
give name.)

Prim. Registration District No. 1010 Local Registrar's No. 15

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-4-</u> <u>1929</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Wayne Owen Lewis
Residence (Usual place of abode) Wenatchee, Ida
If nonresident, give place and State
Color or race White Age at last Birthday 28 (Years)
Birthplace Albee Ore
(City and State or Country)
Occupation Butcher

MOTHER
FULL MAIDEN NAME Nina Mae Lent
Residence (Usual place of abode) Wenatchee, Ida
If nonresident, give place and State
Color or race White Age at last Birthday 21 (Years)
Birthplace Veta, Pass Colo.
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn } at 2:35 p M.
on the date above stated.

(Signature) Ernest A. Finney
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Wenatchee, Ida
Filed Aug 14 1929 G. H. Hamilton
Registrar.

OCT 28 1963

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67463

PLACE OF DEATH
County of Washington
City of Weese

Registration District No. 87
Primary Registration District No. 1010

Local Registrar's No. 7

(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Wayne Lewis
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M 4. COLOR OR RACE Wht 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 4 - 1929
7. AGE Years Months Days If LESS than 1 day hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Weese
(State or country) Idaho

10. NAME OF FATHER Wayne Lewis

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Mrs. Lint

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Oregon

14. Informant Wayne Lewis
(Address) Weese Idaho

15. Filed July 5th 1929 H. B. Haunthm
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4th 1929
(Month) (Day) (Year)

17. HEREBY CERTIFY, That I attended deceased from July 4th 1929 to July 4th 1929
that I last saw him Still Sick and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.
CONTRIBUTORY Forceps Delivery
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) Ernest J. J. J. M. D.

19. (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hellert Cemetery Date of Burial 7-5-1929

20. Undertaker L. B. Northman Address Weese Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

943203-244-299
PLACE OF BIRTH
RECEIVED AUG 20 1929
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
County of Washington
City of Wheeler
CERTIFICATE OF BIRTH 174401
No. _____ St. _____ Registration District No. 56 State File No. _____
Hospital _____ Primary Registration District No. 1010 Local Registrar's No. 13
FULL NAME OF CHILD Maudie Jane Ruth
(Certificate of no value without full name of child)
Sex of Child female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth July 3 1929
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? none
Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____
FULL NAME FATHER Jim Ruth FULL MAIDEN NAME MOTHER Mable O. Brittain
RESIDENCE _____ RESIDENCE _____
COLOR white AGE AT LAST BIRTHDAY 37 COLOR white AGE AT LAST BIRTHDAY 28
(Years) (Years)
BIRTHPLACE Va. BIRTHPLACE Idaho
OCCUPATION Pool hall clerk OCCUPATION housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was { Born alive } at 10:30 P.
on the date above stated. { Stillborn }
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192_____

Registrar. Address _____
Filed Aug 21 1929 G. K. Knaulth
Registrar.

OF BIRTH

City of

75
Registration District

1925

1925

1925

MOTHER

FATHER

RESIDENCE

AGE AND LAST BIRTHDAY

AGE AND LAST BIRTHDAY

CERTIFICATE OF ADOPTION

(Signature)

There was no attending physician present at the birth of the child. The mother was a native born American citizen and was not married at the time of the birth of the child.

Address

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC FEB 1 1930

PLACE OF DEATH

County of Washington

City of Weaver

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 47

Primary Registration District No. 7010

DO NOT WRITE IN THIS SPACE

State File No. 69376

Local Registrar's No. 22

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Martha Jane Ruth

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

10. NAME OF FATHER James Ruth

11. BIRTHPLACE OF FATHER (city or town) Va.
(State or Country)

12. MAIDEN NAME OF MOTHER Mable Bretnor

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant James Ruth
(Address) Weaver, Idaho

15. Filed Jul 29th, 1929. M. K. Hummel
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5th, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 23, 1929
that I last saw her alive on July 23, 1929
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

premature. 6 1/2 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Marshall, M. D.
July 3, 1929 (Address) Weaver

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery Date of Burial 7-5-1929

20. Undertaker L. B. Norstrom Address Weaver

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED SEP 30 1929

DIVISION OF
VITAL STATISTICS-

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT.
SEP 24 1929

Boise, Idaho

174401

James Ruth
Mrs. Jim Ruth

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Weiser

Dear Madam:-

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Martha Jane Ruth.

PLACE OF BIRTH Weiser DATE OF BIRTH July 3, 1929 SEX OF CHILD Female

1. Number of children born to this mother, including present birth one
2. Number born alive and now living none
3. Born alive but now dead one
4. Number of children stillborn none

(Please write plainly)

Information with reference to
FATHER

Information with reference to
MOTHER

James Malcolm Ruth. Mabel Olive Brittain
(Full name) (Full Maiden name)
Weiser Ida, 152 E Main Weiser Idaho, 152 E W
(Residence) (Residence)

Age at last birthday 38 years. Age at last birthday 29 years
Chinckport Va. Weiser Idaho
(Birthplace) (Birthplace)
Clerk.
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey.
C. K. Macey,
Special Agent, Bureau of the Census.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

595-208-001-415
PLACER COUNTY REC'D OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 174482

County of

City of

No. St.

Registration District No. 2

State File No. 174482

(If born in hospital or institution
give name.)

Prim. Registration District No. 1004 Local Registrar's No. 393

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>y</u>	Date of birth <u>9</u> <u>8</u> <u>1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Charles T. Vincent</u>	MOTHER FULL MAIDEN NAME <u>Frances Davis</u>
---	---

Residence (Usual place of abode) 311 1/2 S. B

Residence (Usual place of abode) same

If nonresident, give place and State

If nonresident, give place and State

Color or race W. Age at last Birthday 22 (Years)

Color or race W. Age at last Birthday 18 (Years)

Birthplace Ida. (City and State or Country)

Birthplace Ida. (City and State or Country)

Occupation mining

Occupation dep.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10 A M.
on the date above stated.

(Signature) A. J. Coats

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address

Filed 9/13 1929 W. H. Rhodes

Registrar.

*Where there was no attending physician or midwife, then the father, householder, or family member, or a willborn child, or one that neither practices nor shows other evidence of the after birth.

I hereby certify that I attended the birth of this child, who was (Name) at (Place) on the (Date) above stated.

(Signature)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Residence (Last place of abode) If nonresident, give place and date Color or race Birthplace (City and State or Country)	FATHER NAME FULL BIRTH DATE (City and State or Country)	MOTHER NAME FULL BIRTH DATE (City and State or Country)
--	--	--

Number of child of this mother, including present birth (a) born alive and now living (b) born alive and now dead (c) born dead	Was a household was used to prevent Ophtalmia neonatorum? (To be answered only in cases of infant birth)
--	---

Name of child Sex Date of birth (City and State or Country)	Name of mother Date of birth (City and State or Country)
--	--

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67715

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004

Local Registrar's No. 233

(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Vincen

(a) Residence. No. 311 South 3rd St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) September 8th 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida
(State or country)

10. NAME OF FATHER Delbert Vincen

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Francis E. Davis

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Delbert Vincen
(Address) Boise

15. Filed 9-10-29 W. R. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born dead
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Breach presentation
faulting
large head
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical
(Signed) A. J. Coats, M. D.

_____, 19____ (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery Date of Burial 9/9 1929

20. Undertaker Schneider & W. Baum Address Boise, Idaho
Dr. Coats

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS,** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

532-240-003-349
PLACE OF BIRTH
RECEIVED SEP 25 1929
County of Blaine
City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____
Registration District No. 28 State File No. 174512
(If born in hospital or institution
give name.) Prim. Registration District No. 2161 Local Registrar's No. 9391
FULL NAME OF CHILD Stillborn Eckersley
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimacy? <u>yes</u>	Date of birth <u>Aug 10 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 8 (a) Born alive and now living 6
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME John A Eckersley
Residence (Usual place of abode) Pocatello
If nonresident, give place and State _____
Color or race White Age at last Birthday 50
Birthplace Richmond Utah (Years)
(City and State or Country)
Occupation Oil & Soap

MOTHER
FULL MAIDEN NAME Rose Lena Curtis
Residence (Usual place of abode) Pocatello
If nonresident, give place and State _____
Color or race White Age at last Birthday 36
Birthplace West Jordan Utah (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M.
on the date above stated.

(Signature) W. Brothers

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Physician or midwife)
Address Pocatello, Idaho

Filed 9-1-29
Registrar [Signature]

NOTED BY THE REGISTRAR THAT THE CHILD IS A NATURAL BORN CITIZEN OF THE UNITED STATES AND THAT THE FATHER AND MOTHER ARE ALSO NATURAL BORN CITIZENS OF THE UNITED STATES.

on the date above stated.

"Where there was no attending physician or midwife, then the father, mother, etc. should make this return. A stillborn child is one that neither produces nor shows other evidence of life after birth."

I hereby certify that I attended the birth of this child who was born on the date above stated.

(2) (Signature)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

(City and State of County) (Date and State of County) (Year)

Color of hair (Color of hair) (Color of hair) (Color of hair)

Color of eyes (Color of eyes) (Color of eyes) (Color of eyes)

Place of birth (Place of birth) (Place of birth) (Place of birth)

Place of residence (Place of residence) (Place of residence) (Place of residence)

Place of birth (Place of birth) (Place of birth) (Place of birth)

Place of residence (Place of residence) (Place of residence) (Place of residence)

Place of birth (Place of birth) (Place of birth) (Place of birth)

Place of residence (Place of residence) (Place of residence) (Place of residence)

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Place of birth (Place of birth) (Place of birth) (Place of birth)

Place of residence (Place of residence) (Place of residence) (Place of residence)

Place of birth (Place of birth) (Place of birth) (Place of birth)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

294-187-003-493
PLACED RECEIVED SEP 25 1929

County of Bannock
City of Pocatello

No. _____ St. _____

Poc. Gen. Hosp. Registration District No. 28 State File No. 174517

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 9386

FULL NAME OF CHILD Stillborn Kimpton

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	— } and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Aug 7</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Ranson Kimpton

Residence (Usual place of abode) 539 W. Benton

If nonresident, give place and State _____

Color or race White Age at last Birthday 41 (Years)

Birthplace Big Wood River, Ida (City and State or Country)

Occupation Carman freight

MOTHER
FULL MAIDEN NAME Opal Wickson

Residence (Usual place of abode) 539 W. Benton

If nonresident, give place and State _____

Color or race White Age at last Birthday 18 (Years)

Birthplace Oregon (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:50 P. M.
on the date above stated.

(Signature) _____

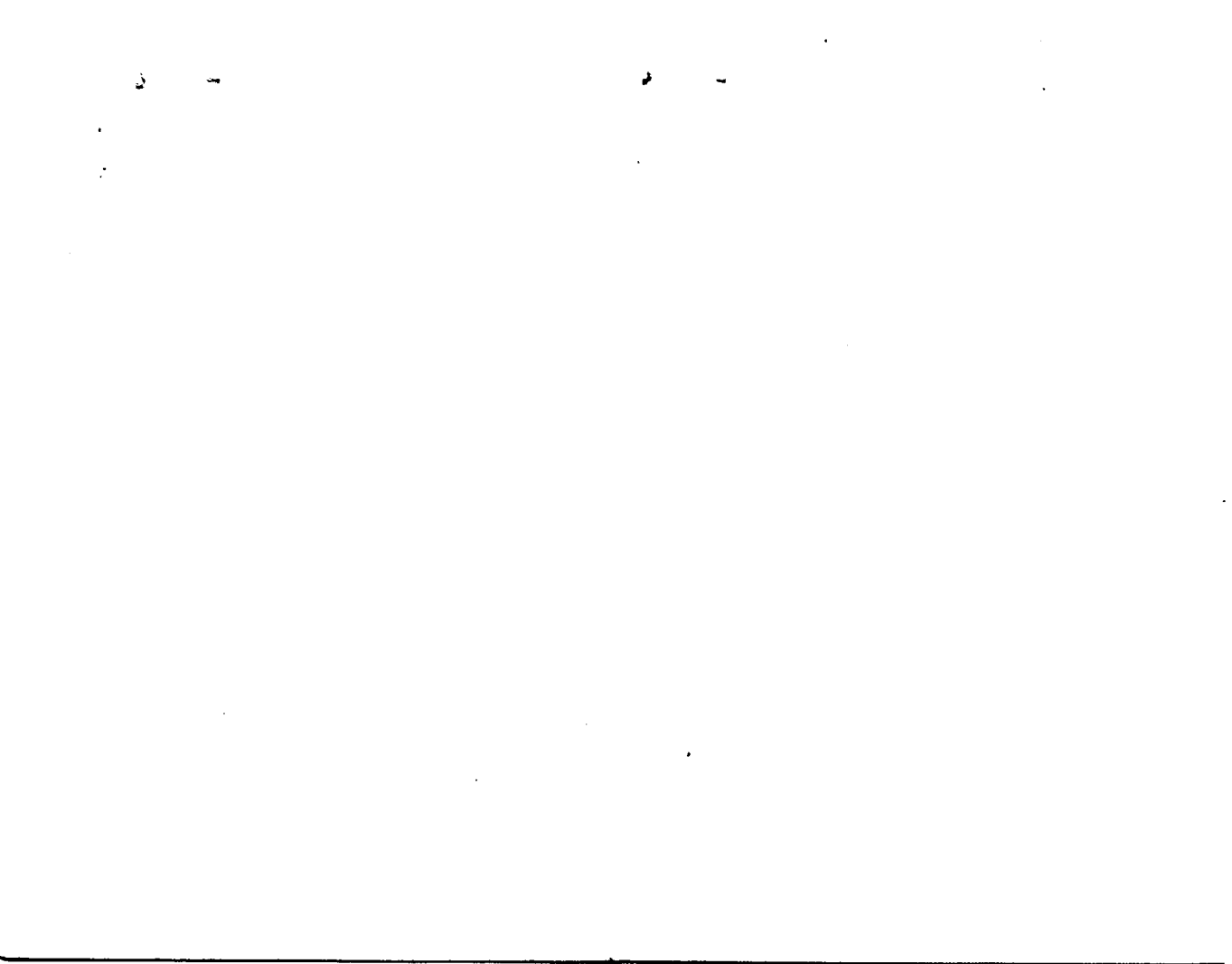
(Physician or midwife)

Address Pocatello

Filed 9/1 19 29

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 22 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67150

PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2141(No. Pocatello)Local Registrar's No. 5632

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Rene Kimpton(a) Residence. No. 539 W. Benton St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

Female whiteSingle5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug 7

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho10. NAME OF FATHER R. Kimpton11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Opal Dixon13. BIRTHPLACE OF MOTHER (city or town) unknown
(State or Country)14. Informant R. Kimpton
(Address) Pocatello Idaho15. Filed Aug 8 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7

(Month)

(Day)

1929
(Year)

17. I HEREBY CERTIFY That I attended deceased from

8/7, 1929, to 8/8, 1929that I last saw him alive on 8/7and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Prolapsd Cord

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) W. H. Young M. D.8/8, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pocatello Idaho Aug 8 1929

20. Undertaker

Address

McNair Undertakers Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

713-126-003-893
PLACE OF BIRTH
RECEIVED SEP 25 1929
County of Bannock
City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174571

No. _____ St.

Poc Hen Hosp
(If born in hospital or institution
give name.)

Registration District No. 28 State File No. _____

Prim. Registration District No. 2161 Local Registrar's No. 9371

FULL NAME OF CHILD

Stillborn Packham

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of

Child male

Twins

Triplet

or other?

(To be answered only in event of plural births)

and

Number

in order

of birth

Legiti-

mate? yes

Date of

birth

(Month)

(Day)

(Year)

July

26

1929

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9

(a) Born alive and now living 8

Born alive but now dead 0

Stillborn 1

FATHER

FULL
NAME

Charles Austin Packham

Residence (Usual place of abode)

Blackfoot

If nonresident, give place and State

Color or race

White

Age at last Birthday

49

Birthplace

No. Ogden Utah

(City and State or Country)

Occupation

Farmer

FULL
MAIDEN
NAME

MOTHER

Mary A. Hickenlooper

Residence (Usual place of abode)

Blackfoot

If nonresident, give place and State

Color or race

White

Age at last Birthday

45

Birthplace

No. Ogden Utah

(City and State or Country)

Occupation

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Stillborn

at

8:15 P. M.

on the date above stated.

(Signature)

W. Broches

(Physician or midwife)

Address

Pocatello Idaho

Filed

9/1 1929

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1950-1951

[illegible]

RECEIVED 10/15/57

0 1110 40 2444 53 71

1. The Commission is authorized to receive and accept gifts of money or property for the purpose of carrying out its functions.

РЕЗУЛЬТАТЫ

1944

100-442888-100

THURSDAY, 20 JULY 1966, 11:00 AM, 1000' 1000' 1000'

[illegible]

*Where there was no attending physician, a substitute, then the father, mother, or grandparent, or other person, was called in to attend the patient.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

269-225-003-294
PLACED RECEIVED SEP 25 1929

County of Idaho
City of Pocatello

STATE OF IDAHO *Dr. Brothers*
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

174587

No. _____ St. _____

Registration District No. 28 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 9415

FULL NAME OF CHILD "Stellburt" Sargatz

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u>	and { Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>Aug 25</u> 19 <u>29</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Paul Sargatz</u>	MOTHER FULL MAIDEN NAME <u>Carlynn Vada Brumgart</u>
---	---

Residence (Usual place of abode) Pocatello

If nonresident, give place and State _____

Color or race White Age at last Birthday 41 (Years)

Birthplace Rome, Germany (City and State or Country)

Occupation Hardware Business

If nonresident, give place and State _____

Color or race White Age at last Birthday 27 (Years)

Birthplace Arcola Ill (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P. M. on the date above stated.

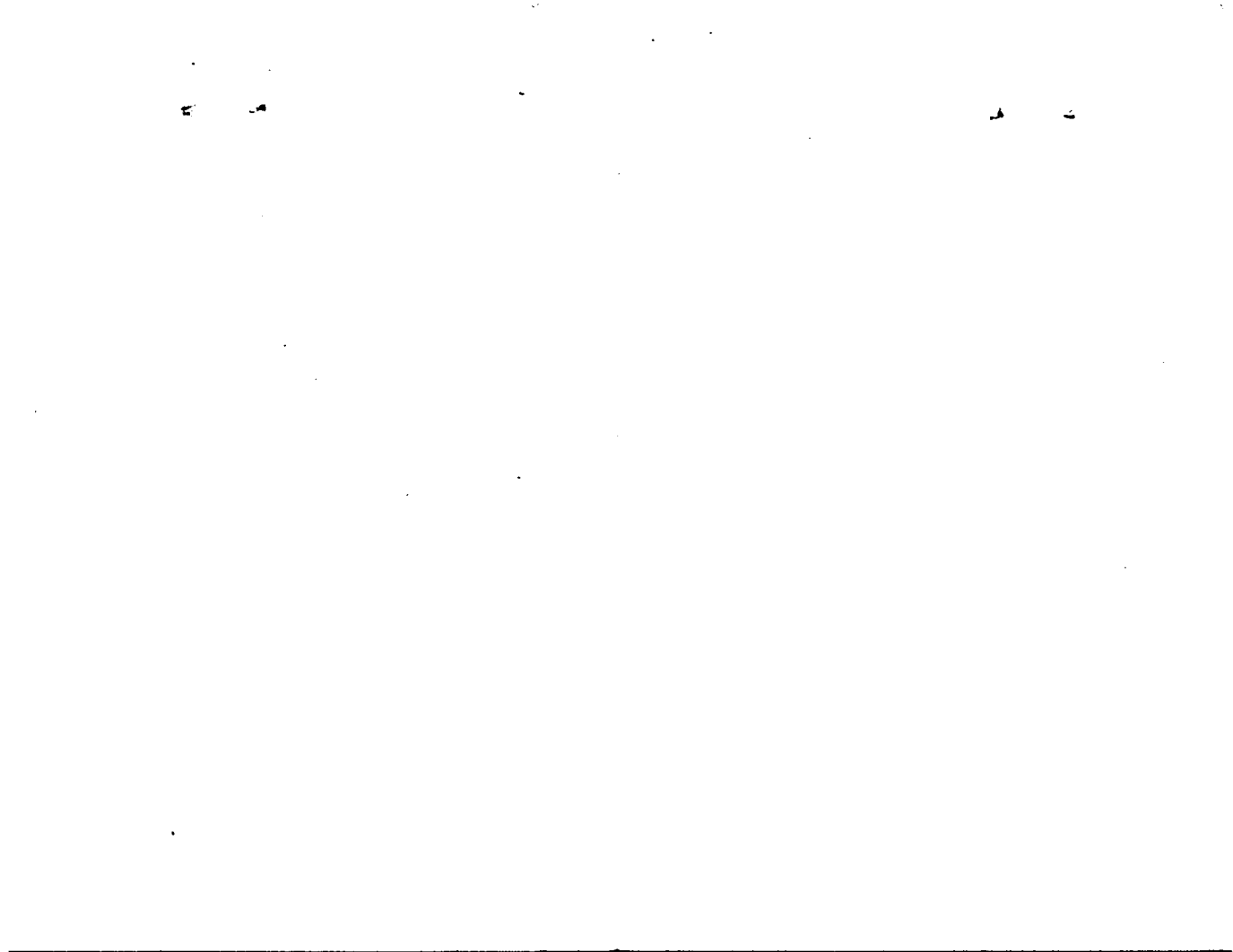
(Signature) W. W. Brothers

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Pocatello, Ida

Filed 9-1 1929 W. W. Brothers Registrar.



RECEIVED SEP 25 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67494

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2141

Local Registrar's No. 5644

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Sorgatz

(a) Residence. No. Pocatello. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed,
or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 25, 1929.

7. AGE

Years

Months

Days

If LESS than 1 day,

Stillborn 0

0

0

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

Paul J. Sorgatz

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Caroline Brumgart

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Illinois.

14. Informant Paul J. Sorgatz

(Address)

Pocatello, Idaho

15. Filed

8/28, 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 25, 1929.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1929, to Aug 25, 1929

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Aluminum 8
mother (duration) yrs. 2 mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Mr Date of

Was there an autopsy? Mr

What test confirmed diagnosis?

(Signed) W. W. Barthen M. D.

8-27, 1929 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS and NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Mountain View Cemetery 8/26/29¹⁹

20. Undertaker

Arthur W. Hall

Address

Poca. Ida.

MARGIN RESERVED FOR INDEXING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH IDAHO OCT 14 1929

County of Camanche
City of Oxford
No. 813-205-003-675 St.

(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174601

Registration District No. 89 State File No. 2100

Prim. Registration District No. 2100 Local Registrar's No. 493

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept - 5 - 1929</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 20%

Number of child of this mother, including present birth 39 (a) Born alive and now living 3

Born alive but now dead no Stillborn no

FATHER FULL NAME <u>Ray Hatch</u>	MOTHER FULL MAIDEN NAME <u>Jane Spenshaw</u>
--------------------------------------	---

Residence (Usual place of abode) <u>Oxford, Ida.</u>	Residence (Usual place of abode) <u>Oxford, Ida.</u>
--	--

If nonresident, give place and State

Color or race <u>white</u>	Age at last Birthday <u>36</u>	Color or race <u>white</u>	Age at last Birthday <u>36</u>
(Years)		(Years)	

Birthplace <u>Oxford, Idaho</u>	Birthplace <u>Paragonah, Utah</u>
(City and State or Country)	(City and State or Country)

Occupation <u>farmer</u>	Occupation <u>banker</u>
--------------------------	--------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. Stillborn at 17 M.

(Signature) H. J. Ostergren M.D.

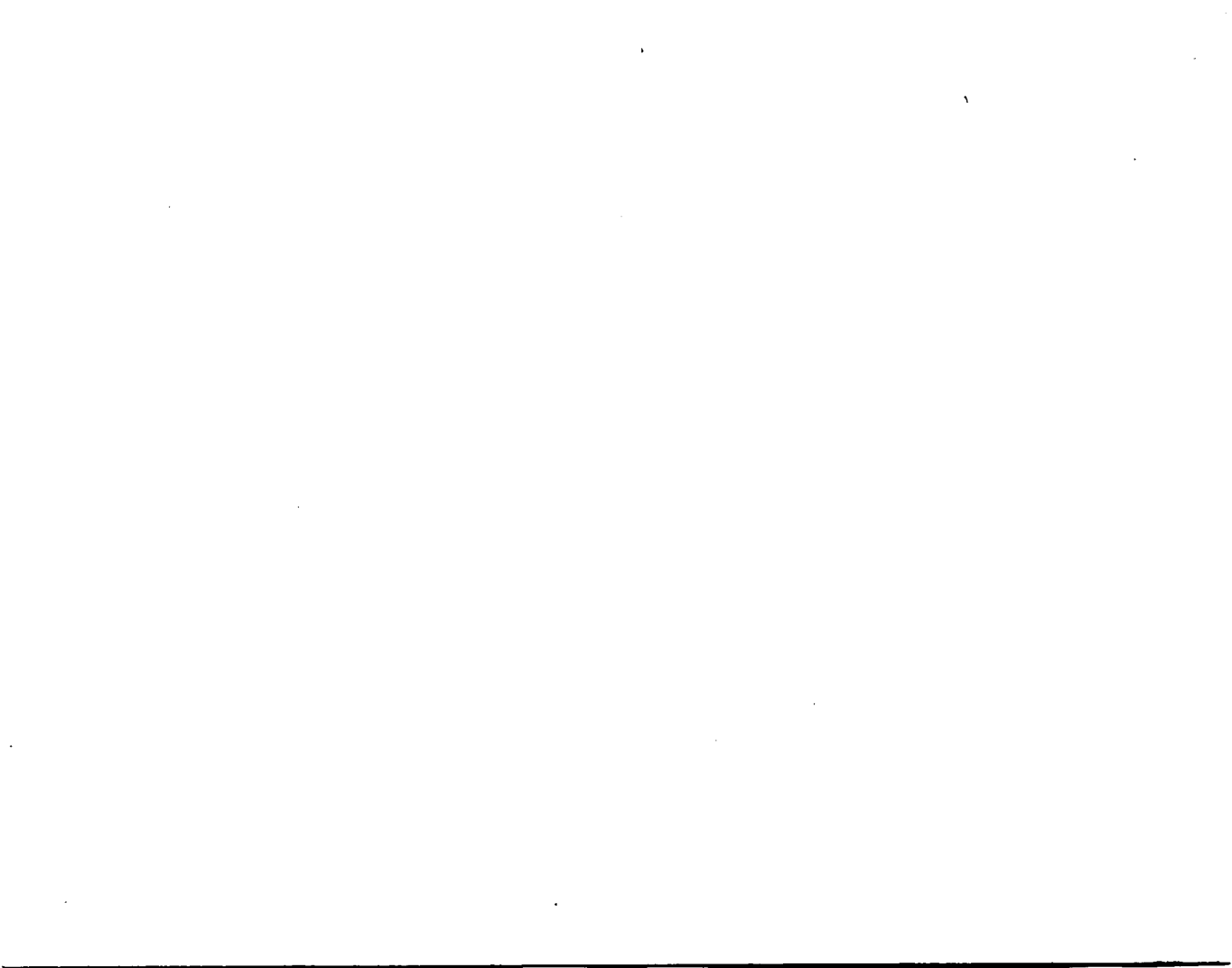
(Physician or midwife)

Address Barney, Idaho

Filed Oct - 10 - 1929 Orary C. Coffin Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

7 Cor.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

413-111-004-155
PLACE OR VIDUOCT 11 1929
County of Bear Lake
City of Liberty
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S**174604

Registration District No. 03 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. _____ Local Registrar's No. 497

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Sept 11</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 7 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Timothy Matthews
Residence (Usual place of abode) Liberty

If nonresident, give place and State _____

Color or race White Age at last Birthday 39 (Years)

Birthplace Idaho
(City and State or Country)

Occupation farmer

MOTHER
FULL MAIDEN NAME Ethel Jensen
Residence (Usual place of abode) Liberty

If nonresident, give place and State _____

Color or race White Age at last Birthday 35 (Years)

Birthplace Idaho
(City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 P. M.
on the date above stated.

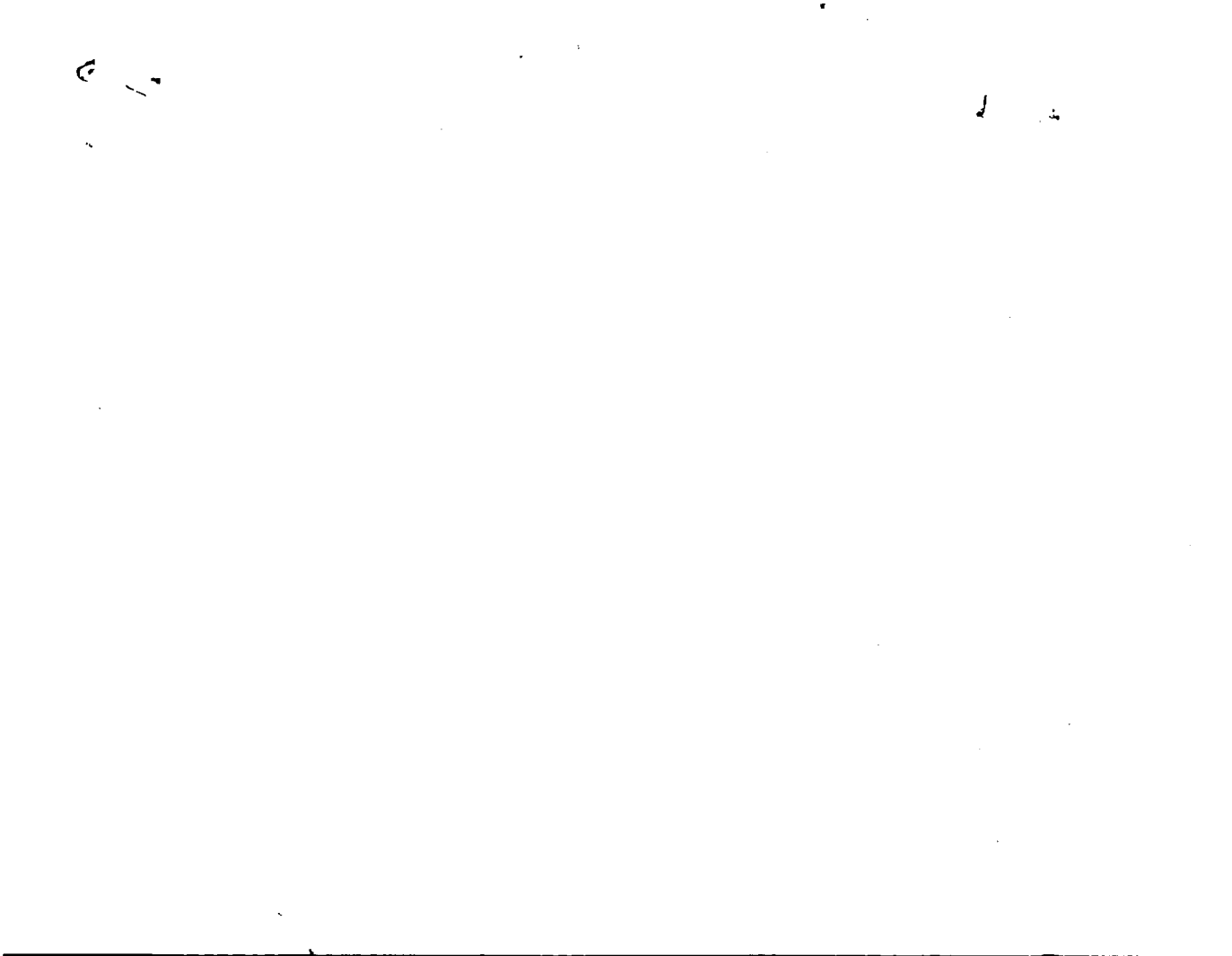
(Signature) O. E. McLean, M.D.

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address _____

Filed 9-30-29 Mrs. J. S. Skinner
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67747

Local Registrar's No. 124

PLACE OF DEATH

County of Bear Lake

City of Liberty

Registration District No. 3-3

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Stillborn

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Sept 11 1929

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

Stillborn.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Idaho

10. NAME OF FATHER

Timothy Matthews

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edith Jensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Idaho

14. Informant

Timothy Matthews
Idaho

(Address)

15. Filed

9-28-29

Mrs. J. S. Skinner

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
(Month)

11
(Day)

1929
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw him alive on, 19

and that death occurred, on the date stated above, at, m.

THE CAUSE OF DEATH* was as follows:

Still born child

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O O Moore, M. D.

Sept 12, 1929 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Liberty Ida

Sept 12 1929

20. Undertaker

Address

T. L. Austin

Liberty Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

219-130-000-706
PLACE OF BIRTH RECEIVED OCT 7 1929
County of Bingham
City of Blackfoot
No. 6 Judicial St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 121 State File No. 174635

Prim. Registration District No. 1007 Local Registrar's No. 212

Stillborn Barrus

(If stillborn, substitute the word "Stillbirth" for name of child)

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twins or Triplets or other? <u>None</u>	and	Number in order of birth <u>1</u>	Legitimate or illegitimate? <u>Yes</u>	Date of birth <u>Sept 20</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	-----	-----------------------------------	--	---

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Golden G. Barrus

Residence (Usual place of abode) Blackfoot

If nonresident, give place and State

Color or race White Age at last Birthday 29 (Years)

Birthplace Oakley Idaho (City and State or Country)

Occupation Lineman Telephone Co

MOTHER
FULL MAIDEN NAME Irene Pool

Residence (Usual place of abode) Blackfoot

If nonresident, give place and State

Color or race White Age at last Birthday 18 (Years)

Birthplace Oklahoma (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was female at 6:30 9 M. on the date above stated.

(Signature) W. Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Blackfoot, Idaho

Filed Oct 2 1929 W. L. Adams Registrar.

1. 2

3. 4

5. 6

7. 8

9. 10

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67518

PLACE OF DEATH

County of BinghamCity of BinghamRegistration District No. 121Primary Registration District No. 1007Local Registrar's No. 166(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillborn Barnes

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Sept 20, 19297. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Blackfoot, Ida
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) Oakley
(State or Country) Idaho12. MAIDEN NAME OF MOTHER Irene Pool13. BIRTHPLACE OF MOTHER (city or town) Oklahoma
(State or Country)14. Informant Golden L. Barnes
(Address) Blackfoot15. Filed Sept 24, 1929 W. W. Beck
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20, 1929, to Sept 20, 1929
that I last saw him alive on Sept 20, 1929and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Premature birth due to
a fall 7th month
(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. W. Beck, M. D.9/20, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Green City Cemetery Sept 21 1929

20. Undertaker

Address

W. W. Beck Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

469-129-010-312
PLA RECEIVED OCT 10 1929
County of Conneville
City of Idaho Falls, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174717

No. 2008308 St.

Registration District No. 73 State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 2 Local Registrar's No. 428

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate

Date of birth

(Month)

(Day)

1929
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead

Stillborn

FATHER
FULL NAME

Alexander Moreno
Idaho Falls, Ida.

Residence (Usual place of abode)

If nonresident, give place and State

Color or race Mexican Age at las. Birthday 26 (Years)

Birthplace Mexico (City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME

Camilla Lazavino
Idaho Falls, Ida.

Residence (Usual place of abode)

If nonresident, give place and State

Color or race Mexican Age at last Birthday 29 (Years)

Birthplace Mexico (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born live }
on the date above stated. { Stillborn } at 2:50 P. M.

(Signature) C. C. C. C.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

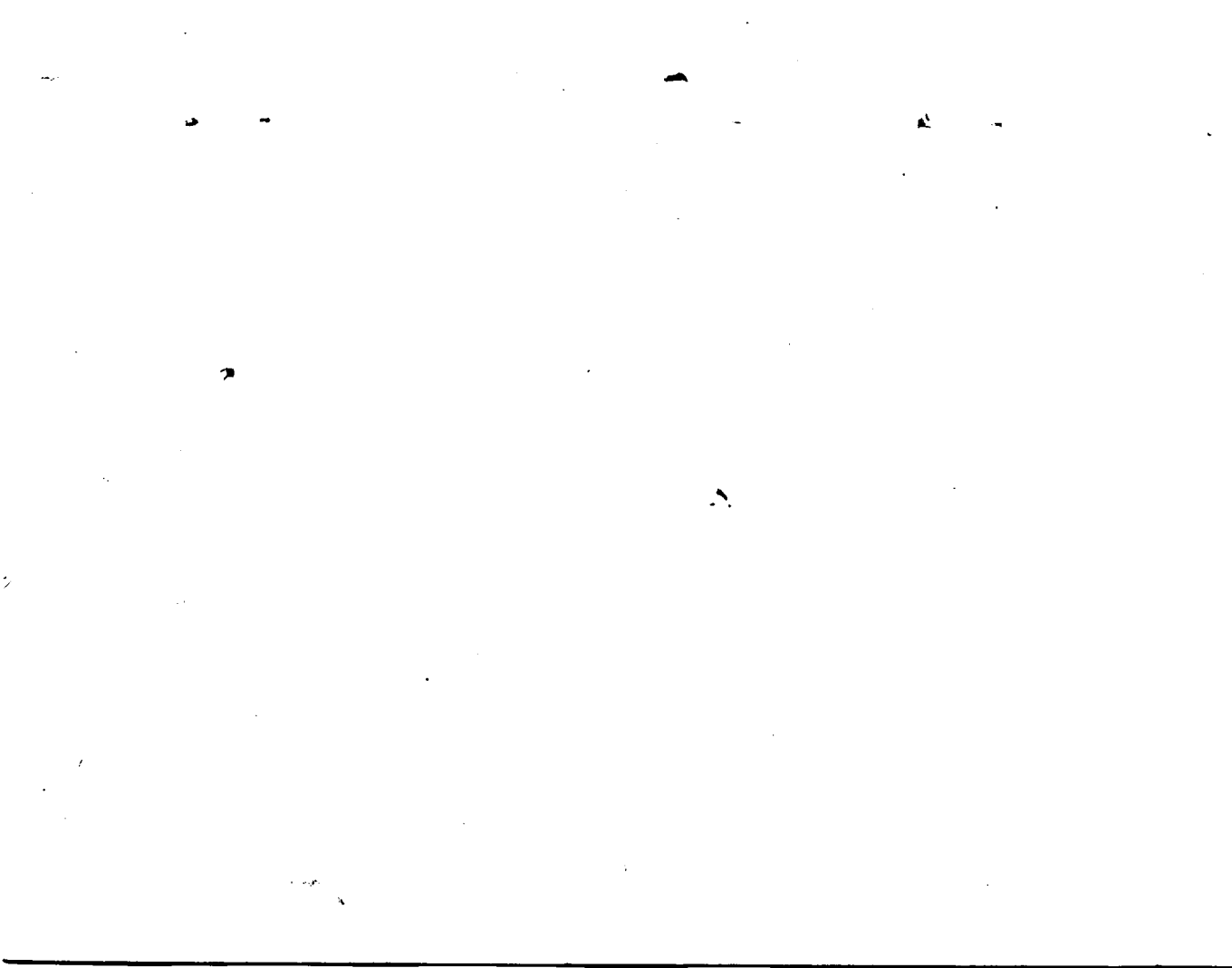
(Physician or midwife)

Address

Filed

1929

Registrar.



RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 97755

PLACE OF DEATH

County of Bonerville CERTIFICATE OF DEATHCity of Idaho Falls Registration District No.

Primary Registration District No.

Local Registrar's No. 177

(No. Hells Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johnnie Emareno

(a) Residence No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE Mexican 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Sept 29 19297. AGE Years Months Days If LESS than 1 day, hrs. or
0 0 0 Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)10. NAME OF FATHER Camilo Emareno11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Mexico12. MAIDEN NAME OF MOTHER Alegan abn. Rozano13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Arizona14. Informant Camilo Emareno
(Address) Idaho Falls15. Filed Sept 30 19 29 Registrar J. J. M. Han

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw him alive on, 19

and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unable to determine

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bill O'Leary M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Idaho Falls 9/30 1929

20. Undertaker Address

V. F. M. Han Idaho FallsIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

613-106-210-431
PLACE OF BIRTH
RECEIVED SEP 19 1929
County of Blaine
City of Idaho Falls, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

174773

No. 1018 St. Harp

Registration District No. 72 State File No. 174773

(If born in hospital or institution give name.)

Prim. Registration District No. 249 Local Registrar's No. 396

FULL NAME OF CHILD Stillborn - Walker

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>Sept 6</u> 1929
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead none Stillborn 1

FATHER	MOTHER
FULL NAME <u>William Walker</u>	FULL MAIDEN NAME <u>Marcia Waters</u>
Residence (Usual place of abode) <u>Ammon Ida.</u>	Residence (Usual place of abode) <u>Ammon Ida.</u>
If nonresident, give place and State.	If nonresident, give place and State.
Color or race <u>W</u> Age at last Birthday <u>49</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>41</u> (Years)
Birthplace <u>Adair City Utah</u> (City and State or Country)	Birthplace <u>Salida Utah</u> (City and State or Country)
Occupation <u>farmer</u>	Occupation <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Idaho Falls on the date above stated.

(Signature) Paul M. Miller

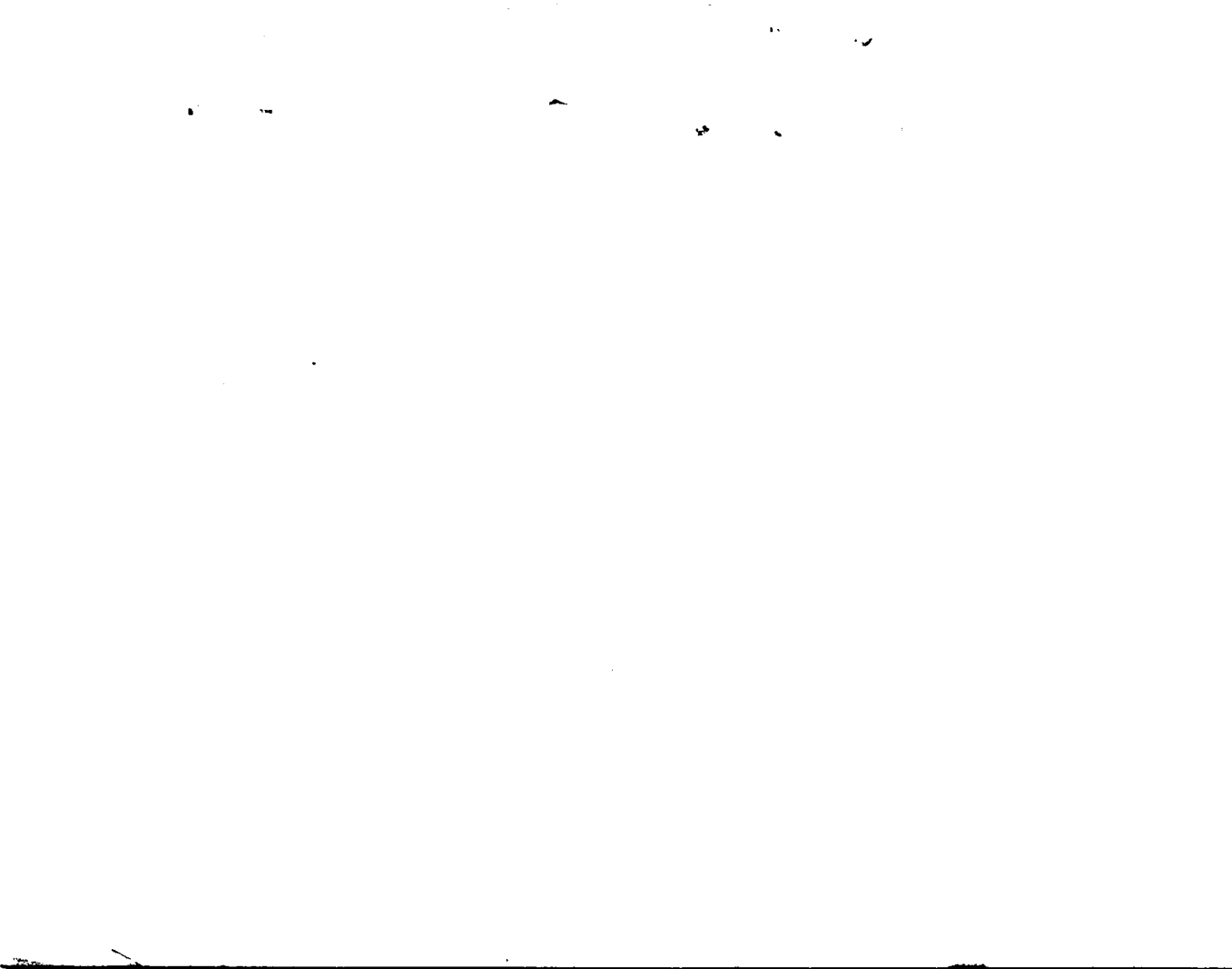
(Physician or midwife)

Address Idaho Falls, Idaho

Filed Sept 10 1929

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED NOV 18 1929

PLACE OF DEATH

County of Bonner
City of Idaho FallsSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 13Primary Registration District No. 2150(No. L. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68245Local Registrar's No. 2072. FULL NAME Infant Walker

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Sept 6 - 19297. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Idaho Falls Ida.
(State or country)

10. NAME OF FATHER

William H. Walker11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Cedar City, Utah

12. MAIDEN NAME OF MOTHER

Marcia Amraters13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Salida, Utah14. Informant Webster Waters
(Address) Idaho Falls - R.D. #315. Filed Sept 10, 1929 W. J. Wainwright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Indefinite
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____

_____, 19____, to _____, 19____,
that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

stillb. born. Cause
rephritis on part of
mother (duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) John O. Miller M. D._____, 19____ (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from violent CAUSES, state (1) MEANS AND NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Falls Ida.Sept 6 1929

20. Undertaker

Address

none

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statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

315-2110-3 OCT 7 1929
RECEIVED
PLACE OR DATE

County of Clearwater
City of Elk River
No. Elk River St.

(If born in hospital or institution
give name.) hospital

FULL NAME OF CHILD

Registration District No. 91 State File No. 174853
Prim. Registration District No. 2168 Local Registrar's No. 17

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth	Legitimate?	Date of birth <u>Sept. 10</u> 192 <u>9</u> (Month) (Day) (Year)
--------------------------	--	-------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? stillborn

Number of child of this mother, including present birth... 6th (a) Born alive and now living... 4
Born alive but now dead... 2 Stillborn one

FATHER FULL NAME <u>Henry E. Savoy</u> Residence (Usual place of abode) <u>Elk River, Idaho</u> If non-resident, give place and State Color or race <u>white</u> Age at last Birthday <u>34</u> (Years) Birthplace <u>Deluth - Minn</u> (City and State or County) Occupation <u>Sawyer</u>	MOTHER FULL MAIDEN NAME <u>Margaret Savoy Vegle</u> Residence (Usual place of abode) <u>Elk River, Idaho</u> If non-resident, give place and State Color or race <u>white</u> Age at last Birthday <u>36</u> (Years) Birthplace <u>Norway</u> (City and State or County) Occupation <u>Housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5 25 P M.
on the date above stated.

(Signature) Walter R. Werelius

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Bozill, Idaho
Filed Oct 3 1929 W. Hambley
Registrar.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Report No. _____
Date _____

Subject _____

Investigator _____
Special Agent in Charge

Location _____
Date _____

Reference _____
File No. _____

Summary _____

Details _____

Conclusion _____

Recommendation _____

Remarks _____

Signature _____
Special Agent in Charge

Stamp _____

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Report No. _____
Date _____

Subject _____

Investigator _____
Special Agent in Charge

Location _____
Date _____

Reference _____
File No. _____

Summary _____

Details _____

Conclusion _____

Recommendation _____

Remarks _____

Signature _____
Special Agent in Charge

Stamp _____

Stamp _____

RECEIVED OCT 7 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Clearwater
City of Elk River

Registration District No. 2168
Primary Registration District No. 2168
(No. St.)

File No. 57601
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillbirth 204

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH Sept 10 1929
(Month) (Day) (Year)

7. AGE still birth at 5 months
Yrs. Mos. ds. IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION none
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho Clearwater County
(State or Country)

10. NAME OF FATHER Wm. E. Lavoie

11. BIRTHPLACE OF FATHER Duluth Minn.
(State or Country)

12. MAIDEN NAME OF MOTHER Margaret Veole

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. E. Lavoie
(Address) Elk River, Idaho

15. Oct 3 1929 M. Hambley
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1929 to Sept 10 1929
that I last saw him alive on Sept 10 1929
and that death occurred on the date stated above, at 5:25 P.M.

The CAUSE OF DEATH* was as follows:
Stillbirth - premature at 5 months

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter R. Wreghitt, M. D.
Sept 10 1929 (Address) Borill, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF D in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certifi

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

212-103-021-243
PLACE OF BIRTH
County of Franklin
City of Duston Ida
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 27 State File No. 174880
Prim. Registration District No. 219 Local Registrar's No.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Sept. 3 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Wile S. Bastian

Residence (Usual place of abode) Western, Ida

If nonresident, give place and State _____

Color or race white Age at last Birthday 40
(Years)

Birthplace Utah
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Ethel Sullivan

Residence (Usual place of abode) Western, Ida

If nonresident, give place and State _____

Color or race white Age at last Birthday 46
(Years)

Birthplace Utah
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at _____ M.
on the date above stated.

(Signature) A. R. Cutler

(Physician or midwife)

Address Duston, Ida

Filed 9-12-1929 A. R. Cutler

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

174880

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67964

PLACE OF DEATH

County of FranklinCity of Weston, IdaRegistration District No. 27Primary Registration District No. 2119Local Registrar's No. 206

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME _____

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Sept. 3 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) Stillborn

(c) Name of employer _____

9. BIRTHPLACE (city or town) _____
(State or country)10. NAME OF FATHER Niels S. Bastian11. BIRTHPLACE OF FATHER (city or town) _____
(State or Country) Utah12. MAIDEN NAME OF MOTHER Ethel Sullivan13. BIRTHPLACE OF MOTHER (city or town) _____
(State or Country) Utah14. Informant _____
(Address)15. Filed Sept. 6, 1929Registrar A. P. Quiley

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Stillborn cause
unknown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____, M. D.

_____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____

19

20. Undertaker _____

Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

312-218-028-689

PLACE OF BIRTH

County of Adair

City of Coeur d'Alene

No. 315 Garden St.

C. H. H.

(If born in hospital or institution give name.)

Registration District No. 30 State File No. S 174936

Prim. Registration District No. 1050 Local Registrar's No. 163

FULL NAME OF CHILD Gene Case

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and { Number in order of birth <u>1</u> }	Legitimate? <u>Yes</u>	Date of birth <u>9 18 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____

Born alive but now dead _____

Stillborn Yes

FATHER
FULL NAME

Ashley B. Case

MOTHER
FULL MAIDEN NAME

Marguerite White

Residence (Usual place of abode)

Coeur d'Alene, Ida.

Residence (Usual place of abode)

Coeur d'Alene, Ida.

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race W.

Age at last Birthday 43

(Years)

Color or race W.

Age at last Birthday 34

(Years)

Birthplace Howell, Mich.

(City and State or Country)

Birthplace Wallace, Ida.

(City and State or Country)

Occupation Taylor

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { Not alive } at 745 P. M.
on the date above stated.

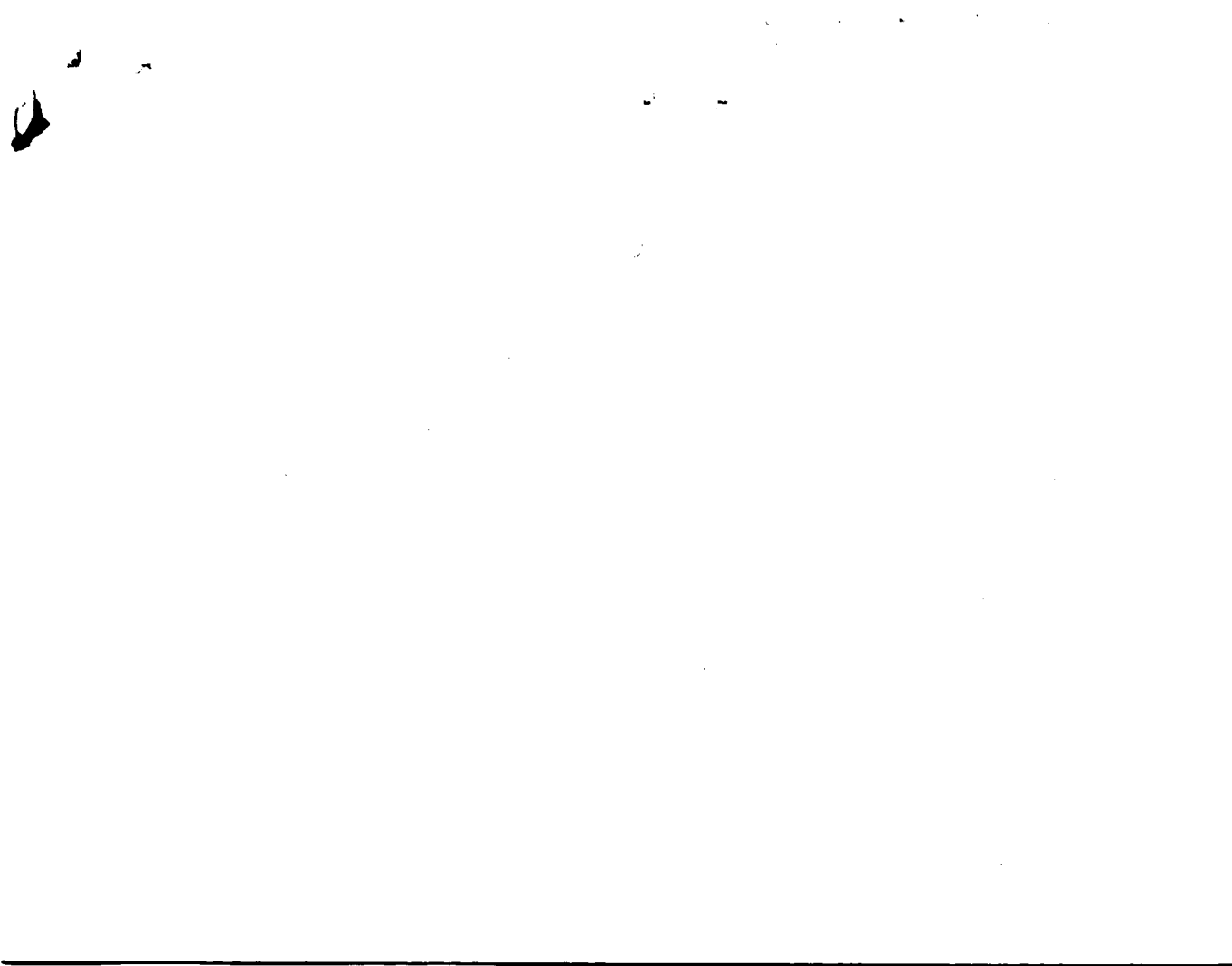
(Signature) Dr. J. T. Wood

(Physician or midwife)

Address C. H. H.

Filed 9/28 1929 N. J. Sturges
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

17/19

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 67621

PLACE OF DEATH
County of Rootenau
City of Coeur d'Alene

Registration District No.
Primary Registration District No.
(No. 220' a. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 158

2. FULL NAME Infant Case
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years <u>0</u>	Months <u>0</u>	Days <u>0</u>
If LESS than 1 day, hrs. or min. <u>0</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) (State or country) <u>Coeur d'Alene Idaho</u>
10. NAME OF FATHER <u>A. B. Case</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Idaho</u>
12. MAIDEN NAME OF MOTHER <u>Mary M White</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>
14. Informant <u>A B Case</u> (Address) <u>Coeur d'Alene Idaho</u>
15. Filed <u>9/28</u> , 19 <u>29</u> <u>H. J. Sturges</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH <u>Sept 18</u> 19 <u>29</u> (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from <u>Sept 18</u> , 19 <u>29</u> , to that I last saw him alive on and that death occurred, on the date stated above, at The CAUSE OF DEATH was as follows: <u>Still-born</u> <u>Megaloccephalia</u> (duration) yrs. mos. ds. CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 18. Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? What test confirmed diagnosis? (Signed) <u>John O'Leary</u> M.D. <u>Sept 19</u> , 19 <u>29</u> (Address) <u>Coeur d'Alene Idaho</u> *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 19. Place of Burial, Cremation, or Removal <u>Forest Cemetery</u> Date of Burial <u>Sept 19</u> 19 <u>29</u> 20. Undertaker <u>R. B. Mooney</u> Address <u>Coeur d'Alene</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

893-125-028-419
PLACE OF BIRTH
RECEIVED OCT 10 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11—20m-7-26-19

S

174941

County of *Kootenai*

City of *Post Falls*

Registration District No. *30*

File No. *174941*

No. _____ St. _____

Primary Registration District No. *1050*

Registered No. *167*

Hospital _____

FULL NAME OF CHILD

Still-born-Hill

Sex of Child

male

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
(of birth)

Legiti-
mate?

yes

Date of
Birth

Aug 25 1929
(Month) (Day) (Year)

FULL
NAME

FATHER
Jan B. Hill

FULL
MAIDEN
NAME

MOTHER
Edith Darrow

RESIDENCE

Post Falls

RESIDENCE

Post Falls, Ida

COLOR

white

AGE AT LAST
BIRTHDAY

23
(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

21
(Years)

BIRTHPLACE

Ida

BIRTHPLACE

Ida

OCCUPATION

Common Laborer

OCCUPATION

House Keeper

Number of child of this mother, including present birth *1*

Number of children of this mother now living, including present birth *2*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Stillborn, at *145* A. M.
F. L. McCauley
Phys.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Coeur d'Alene Ida

Filed

9/28-

1929

W. J. Sturges

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

249-201-029-738

PLACE OF RECEIVED

SEP 25 1929

STATE OF IDAHO

S

County of LATAH

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of

CERTIFICATE OF BIRTH

No. St.

Registration District No. 65 State File No. 174968

(If born in hospital or institution
give name.)

Prim. Registration District No. 2445 Local Registrar's No.

FULL NAME OF CHILD STILLBIRTH

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>FEMALE</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and {	Number in order of birth	Legitimate? <u>YES</u>	Date of birth <u>SEPTEMBER 1 1929</u> (Month) (Day) (Year)
----------------------------	---	-------	--------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? NO

Number of child of this mother, including present birth 8 (a) Born alive and now living 6

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME HOMER RAY SMITH

MOTHER
FULL MAIDEN NAME ELLEN CLYDE

Residence (Usual place of abode) LATAH CO

Residence (Usual place of abode) LATAH CO

If nonresident, give place and State

If nonresident, give place and State

Color or race WHITE Age at last Birthday 45 (Years)

Color or race WHITE Age at last Birthday 41 (Years)

Birthplace CANNON CO IOWA
(City and State or Country)

Birthplace LATAH
(City and State or Country)

Occupation FARMER

Occupation HOUSEWIFE

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 12:15 P. M. on the date above stated.

(Signature) Hyden Stanchman MD

Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Potlatch - Idaho

Filed Sept 10 1929 D. J. Thompson
Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED SEP 20 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 174970

County of Latah
City of Boothatch
No. 432-216.029-212 St.

Registration District No. 65 State File No. 2145

(If born in hospital or institution
give name.)

Prim. Registration District No. 2145 Local Registrar's No. Stillbirth

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	{ Twin Triplet or other? <input checked="" type="checkbox"/> }	{ Number in order of birth <input checked="" type="checkbox"/> }	Legitimate? <u>yes</u>	Date of birth <u>Sept. 16</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	--	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Donald W. Kuning

MOTHER
FULL MAIDEN NAME Ruth Babo

Residence (Usual place of abode) Boothatch

Residence (Usual place of abode) Boothatch

If nonresident, give place and State ✓

If nonresident, give place and State

Color or race white Age at last Birthday 35 (Years)

Color or race white Age at last Birthday 18 (Years)

Birthplace Minnesota

Birthplace Bozeman Wash. (City and State or Country)

Occupation Laborer

Occupation Housewife

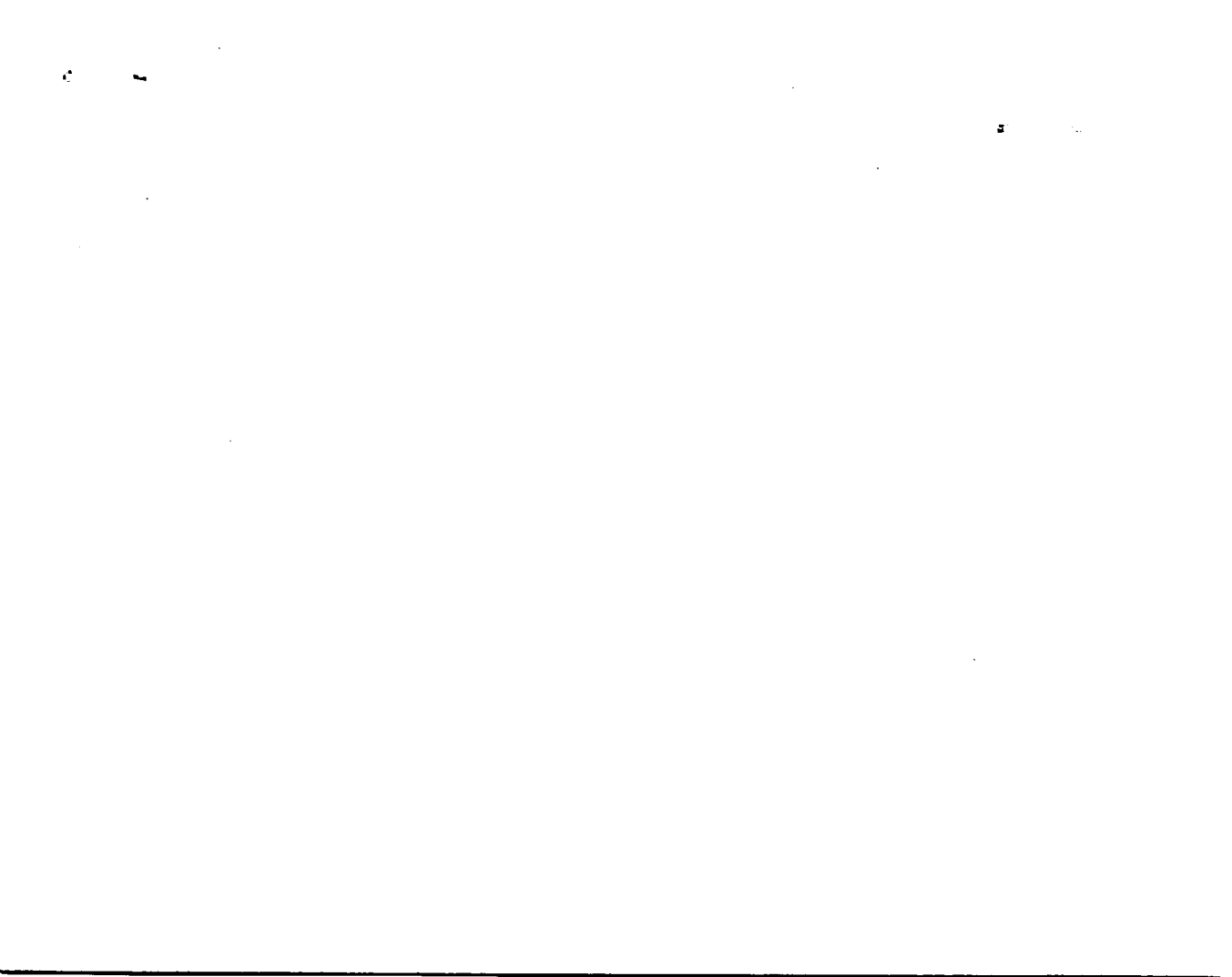
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive ☒ Stillborn } at 6 A. M.
on the date above stated.

(Signature) D. W. Thompson
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Boothatch
Filed Sept. 17 1929 D. W. Thompson Registrar.



RECEIVED SEP 25 1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Latah
City of PotlatchRegistration District No. 65
Primary Registration District No. 2125
(No. _____ St.)File No. 67640
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed. babe of Donald M. Kennedy
If death occurred in a hospital, institution or camp, give the NAME instead of and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Sept 16 1929
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or 0 min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Potlatch

10. NAME OF FATHER

Donald M. Kennedy

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Ruth Babbo

13. BIRTHPLACE OF MOTHER

(State or Country)

Golfar. Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Donald M. Kennedy

(Address)

Potlatch

15.

Filed

Sept 17 1929 D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19 to ✓ 19
that I last saw him alive on ✓ 19
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Signature Ruth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. W. Thompson

M. D.

9/17/1929(Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Potlatch Cemetery

DATE OF BURIAL

Sept 17 1929

20. UNDERTAKER

Parents

ADDRESS

Potlatch

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

517-302.035-212
RECEIVED SEP 23 1929
of *My Sister*
Leviator

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

175047

No. _____ St. _____
St. Joseph's
Registration District No. *96* State File No. _____
(If born in hospital or institution give name.)
Prim. Registration District No. *1009* Local Registrar's No. _____
FULL NAME OF CHILD *Stillbirth*
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <i>Female</i>	Twin Triplet or other? _____	and {	Number in order of birth <i>2nd</i>	Legitimate? <i>No</i>	Date of birth <i>Aug. 7 1929</i> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth *2* (a) Born alive and now living *1*

Born alive but now dead *None* Stillborn *One*

FATHER FULL NAME <i>Chief White Eagle</i>	MOTHER FULL MAIDEN NAME <i>May Basco</i>
--	---

Residence (Usual place of abode) *unknown* *Lapwai Ida*

If non-resident, give place and State _____

Color or race *Indian* Age at last Birthday *27* (Years)

Birthplace _____ (City and State or County) *Spalding Ida*

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Stillborn* *Born alive* at *7:00 P.* M. on the date above stated.

(Signature) *W. C. Clark*
Physician
(Physician or midwife)

Address *Function Idaho*

Filed *Sept-8 1929* *Swan E. Bruce*
Deputy

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

155045

Registration District No. _____ State File No. _____
 Prim. Registration District No. _____ Local Registrar's No. _____

(If born in hospital or institution give name)

FULL NAME OF CHILD

(If surname, substitute the word "Schilder" for name of child)

Sex of child _____
 Date of birth _____
 (Month) (Year)
 (To be answered only in case of twins)
 Twin _____
 and in order _____
 of birth _____
 (To be answered only in case of twins)
 (To be answered only in case of twins)
 (To be answered only in case of twins)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth _____

Born alive and now dead _____

FATHER _____

MOTHER _____

Place of birth _____

Place of birth _____

Age at last birthday _____

Birthplace _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

on the date above stated.

(Signature)

(Physician or midwife)

Address _____

Filed _____

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

REMARKS: I am a child of a mother who is now in the hospital and is being treated for a disease of the lungs. I was born in the hospital and was given the name of _____.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

383-224-035-689
PLACE OF BIRTH

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
175059

County of Blaine
City of Leaverton, Idaho
No. _____ St. _____ Registration District No. 96 File No. _____
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. _____
FULL NAME OF CHILD Helen Ann Tyler

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>8-24</u> (Month) (Day) (Year) <u>1929</u>
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What bacteriocidal solution was used in eyes? Simms Nitrates

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Mrs. L. Tyler</u>	FULL MAIDEN NAME <u>Helen White</u>		
RESIDENCE <u>Leaverton, Idaho</u>	RESIDENCE <u>Leaverton, Idaho</u>		
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>26</u> (Years)		
BIRTHPLACE <u>Helen, Mont.</u>	BIRTHPLACE <u>Leaverton, Idaho</u>		
OCCUPATION <u>Insurance Co. Salesman</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

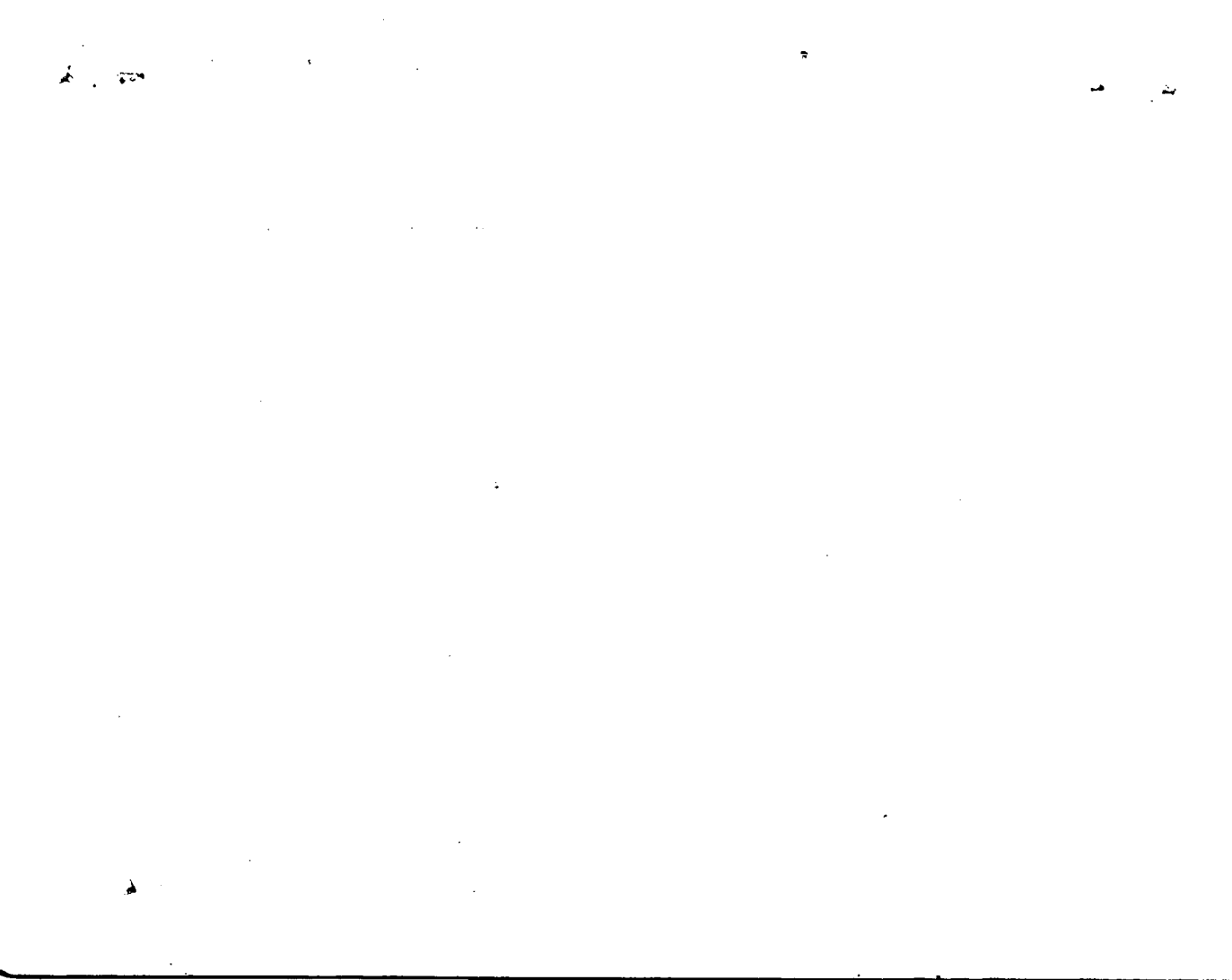
(Signature) E. E. Broadrock
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed Sept 8 1929 Susan E. Bruce
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67669

PLACE OF DEATH
County of Myer
City of Lewiston

Registration District No. 96Primary Registration District No. 1004Local Registrar's No. 706(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Ann Tyler(a) Residence. No. Lewiston St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug 24 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)10. NAME OF FATHER M. L. Tyler11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Helen Mont12. MAIDEN NAME OF MOTHER Helen White13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Lewiston Idaho14. Informant M. L. Tyler
(Address) Lewiston Idaho

15. Filed _____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 24, 1929, to Aug 24, 1929that I last saw her alive on Aug 24, 1929and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Still Born
(Breech Presentation)
(duration) yrs. mos. 1 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) E. S. Braddock, M. D.Aug 26, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Lewiston Idaho Date of Burial Aug 27 192920. Undertaker Assar Motuary Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

3-119.035-238
PLACE OF BIRTH
County of Blaine
City of Lewiston

No. _____ St. _____

St. Joseph's
(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 96 State File No. 175061

Prim. Registration District No. 1009 Local Registrar's No. _____

Raymond Albin Oslund (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth <u>1st</u> }	Legitimate? <u>Yes</u>	Date of birth <u>Aug. 19 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth One (a) Born alive and now living None

Born alive but now dead None Stillborn One

FATHER FULL NAME <u>Albin Oslund</u>	MOTHER FULL MAIDEN NAME <u>Belle Schmadeka</u>
---	---

Residence (Usual place of abode) _____

If non-resident, give place and State Clarkston, Wash.

Color or race White Age at last Birthday 36 (Years)

Birthplace Idaho (City and State or County)

Occupation Carpenter

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:15 P. M.
on the date above stated.

(Signature) Paul Johnson

(Physician or midwife)

Address Lewiston, Ida.

Filed Sept-8-1929 Dwain E. Bruce
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67672

PLACE OF DEATH
County of Nezperce
City of Lewiston, Ida

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No. St. Joseph's Hospital)
(If death occurred in a hospital or institution, give its name and its registered number.)

2. FULL NAME Raymon Albin Oslund

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 8/19/29
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)

10. NAME OF FATHER O.A. Oslund

11. BIRTHPLACE OF FATHER (city or town) Troy, Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Belle Schmaddka

13. BIRTHPLACE OF MOTHER (city or town) Grangeville, Idaho
(State or Country)

14. Informant O A Oslund
(Address) Clarkston, Wash.

15. Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1929 to Aug 19 1929
that I last saw him alive on born dead
and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH was as follows:
mother had nephritis,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul W. Johnson M. D.
Aug 21 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clarkston, Wash.
Date of Burial 8/21/29 19

20. Undertaker H.R. Merchant Clarkston Wn.
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

67675
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

453-115-035-766
RECEIVED SEP 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

175065

County of Nez. Pers.
City of Lewiston, Ida.

No. _____ St. Registration District No. 96 State File No. _____

Hospital St. Joseph's Primary Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Denny Franklin Decieis

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 15</u> 192 <u>9</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth - 1 - Number of child of this mother now living, including present birth - 0 -

FATHER	MOTHER
FULL NAME <u>Jorch Decieis</u>	FULL MAIDEN NAME <u>Gene Powell</u>
RESIDENCE <u>North Lewiston</u>	RESIDENCE <u>same</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Ida.</u>	BIRTHPLACE <u>Ida.</u>
OCCUPATION <u>R.R. Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4.00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

William H. Habel

(Physician or midwife)

Address

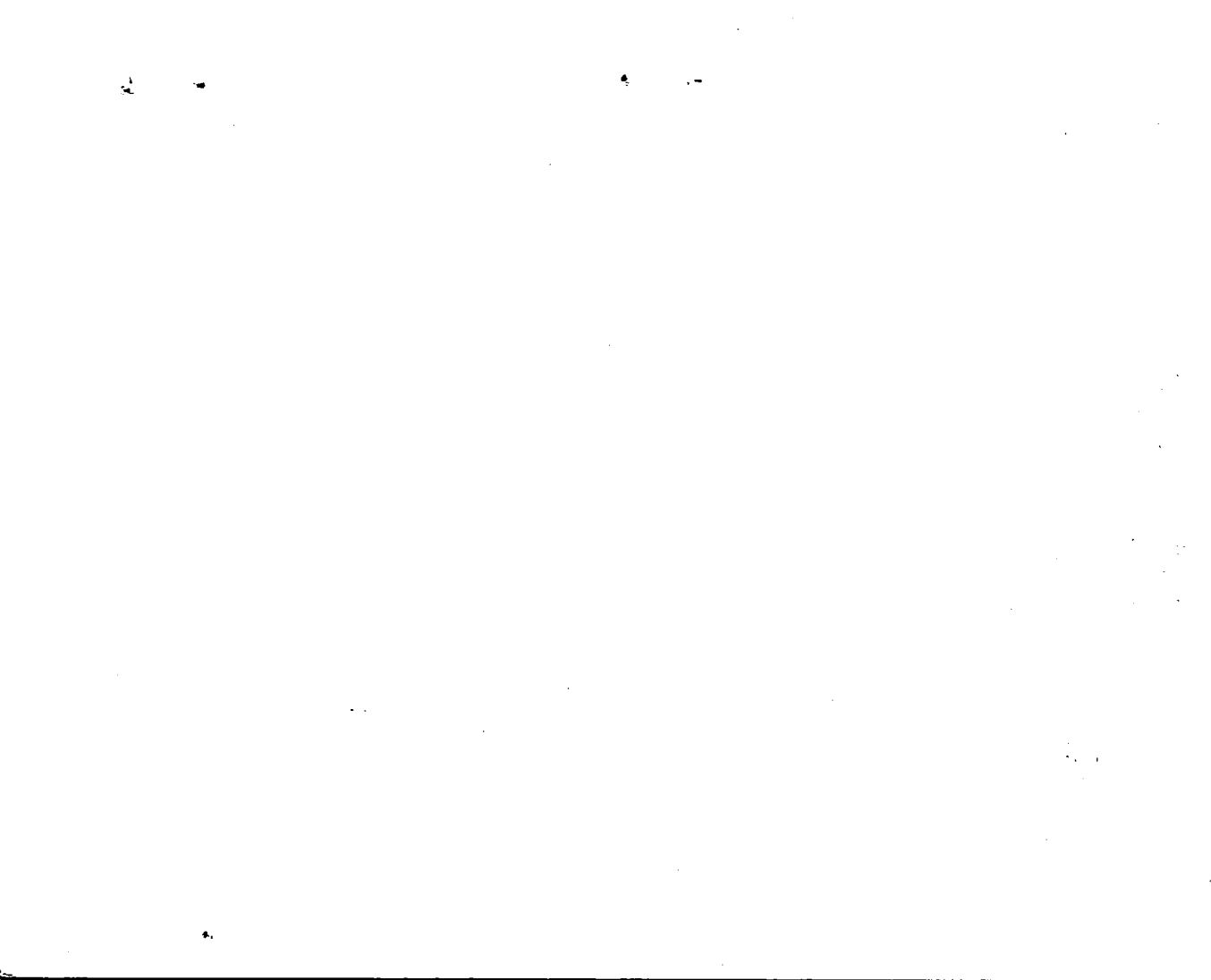
Lewiston - Ida.

Filed

Sept-8 1929 Susan E Bruce

Registrar.

Registrar.



RECEIVED SEP 23 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67675

County of Payette
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie Franklin Decisio

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 15 - 1929
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

10. NAME OF FATHER Forch Decisio

11. BIRTHPLACE OF FATHER (city or town) Lewiston Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Lone Powell

13. BIRTHPLACE OF MOTHER (city or town) Sagle Idaho
(State or Country)

14. Informant Forch Decisio
(Address) Lewiston Idaho

15. Filed Sept. 8, 1929 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pneumonia 5 1/2 months.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? W. H. A. H. A. H. M. D.
(Signed) 8/16, 1929 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 8/16 1929

20. Undertaker Brower-Wannick Address Lewiston, Idaho

MAY 19 1949

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

818-111-0358-754
PLACE OF BIRTH
RECEIVED SEP 24 1929

County of Payette
City of _____
No. _____ St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 175100

Registration District No. 4 State File No. _____
Prim. Registration District No. 1008 Local Registrar's No. 51

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? Yes	Date of birth <u>Aug. 11, 1929</u> (Month) (Day) (Year)
-----------------------------	---	---	----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Gilbert Hayes
Residence (Usual place of abode) Payette, Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 27 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Eunice Pemberton
Residence (Usual place of abode) Payette, Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 22 (Years)
Birthplace Oklahoma
(City and State or Country)
Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
on the date above stated. {
Born alive { Stillborn {
Stillborn {
at 4.00 a.m. M.

(Signature) J. C. Woodward
Physician.
(Physician or midwife)

Address Payette, Idaho
Filed Sept 29 1929 J. C. Woodward
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

THE UNIVERSITY OF CHICAGO

RETURN TO SEADUTRA

1. Johnnie Lee Robinson

100-443887-100

Q. 170 90 112 113

[illegible]

SECRET CONFIDENTIAL

המחלקה הכלכלית והסטטיסטית

14-00000

SECRET

12-11-68

10-10-68

[illegible]

100-10117

... blind and to direct that the said blind be filled with ...

There was no other information.

1. The first of these is the fact that the majority of the population of the United States is of European descent. This is a fact which has been recognized by the government and the people of the United States for many years. It is a fact which has been recognized by the government and the people of the United States for many years.

April 64

[Faint, illegible markings]

Information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 24 1929

PLACE OF DEATH

County of Payette

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Kayse

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Aug 10 - 29

7. AGE

Years

Months

Days

LESS than 1 day,

hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Payette Ida.

10. NAME OF FATHER

Gilbert Kayse

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Ermine Pemberton

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Kentucky

14. Informant

Ermine Pemberton
Payette Ida.

(Address)

15. Filed

Aug 12, 1929, J. C. Woodward
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 67692

Local Registrar's No. 30

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11, 1929, to Aug 11, 1929

that I last saw him alive on

and that death occurred, on the date stated above, at 4:00 a m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. C. Woodward M. D.

Aug 12, 1929 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Manassas Creek, Aug 11, 1929

Undertaker

Address

Ermine C. Pemberton, Payette Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED SEP 20 1929

County of Cayuse
City of New Plymouth

No. 369-203-038-314 St. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Registration District No. 5 State File No. 175107

Prim Registration District No. 1009 Local Registrar's No. 13

La Vada Marie Corbin

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	{ and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 3</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>William L. Corbin</u>	MOTHER FULL MAIDEN NAME <u>Sadie Loughery</u>
--	--

Residence (Usual place of abode) New Plymouth, Ida.

It non-resident, give place and State _____ If non-resident, give place and State _____

Color or race White Age at last Birthday 52 (Years)

Birthplace Iowa (City and State or County)

Occupation Laborer

Color or race White Age at last Birthday 34 (Years)

Birthplace Idaho (City and State or County)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P. M.
on the date above stated.

(Signature) M. J. Weese, M.D.

(Physician or midwife)

Address Ontario, Oregon

Filed Aug 9 1929 Wm. J. Brysdale Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED NOV 21 1929

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C. K. MACEY
SPECIAL AGENT.

Boise, Idaho

OCT 22 1929

175107

Mrs. W. L. Corbin

New Plymouth

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:-

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD LaVada Marie Corbin

PLACE OF BIRTH New Plymouth DATE OF BIRTH Aug. 3 SEX OF CHILD Female

1. Number of children born to this mother, including present birth Three
 2. Number born alive and now living two
 3. Born alive but now dead None
 4. Number of children stillborn one

(Please write plainly)

Information with reference to
FATHER

Information with reference to
MOTHER

William Lorin Corbin
(Full name)

Sarah LaVada Lenaghan
(Full maiden name)

New Plymouth, Ida
(Residence)

New Plymouth
(Residence)

Age at last birthday fifty two

Age at last birthday thirty four

Colo Kansas
(Birthplace)

Middleton Idaho
(Birthplace)

Laborer
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C. K. Macey,
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168-117-001-243
RECEIVED NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of _____

City of _____

No. _____ St. _____

(If born in hospital or institution
give name.)

Registration District No. 2

State File No. 175270

Prim. Registration District No. 1004

Local Registrar's No. 437

FULL NAME OF CHILD

Stillbirth

Premature

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

M.

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month)

(Day)

(Year)

10

17

1929

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

2

(a) Born alive and now living

1

Born alive but now dead

1

Stillborn

1

FATHER
FULL NAME Harry O. Johnson

MOTHER
FULL MAIDEN NAME Helen Buchanan

Residence (Usual place of abode)

1111 1/2 grove

Residence (Usual place of abode)

same

If nonresident, give place and State

If nonresident, give place and State

Color or race

W.

Age at last Birthday

25

(Years)

Color or race

W.

Age at last Birthday

19

(Years)

Birthplace

Ida.
(City and State or Country)

Birthplace

Ida.
(City and State or Country)

Occupation

Truck driver

Occupation

Lib.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

mother frightened +

Born alive

midnight

miscarried

(Signature)

A. J. Coatsworth

(Physician or midwife)

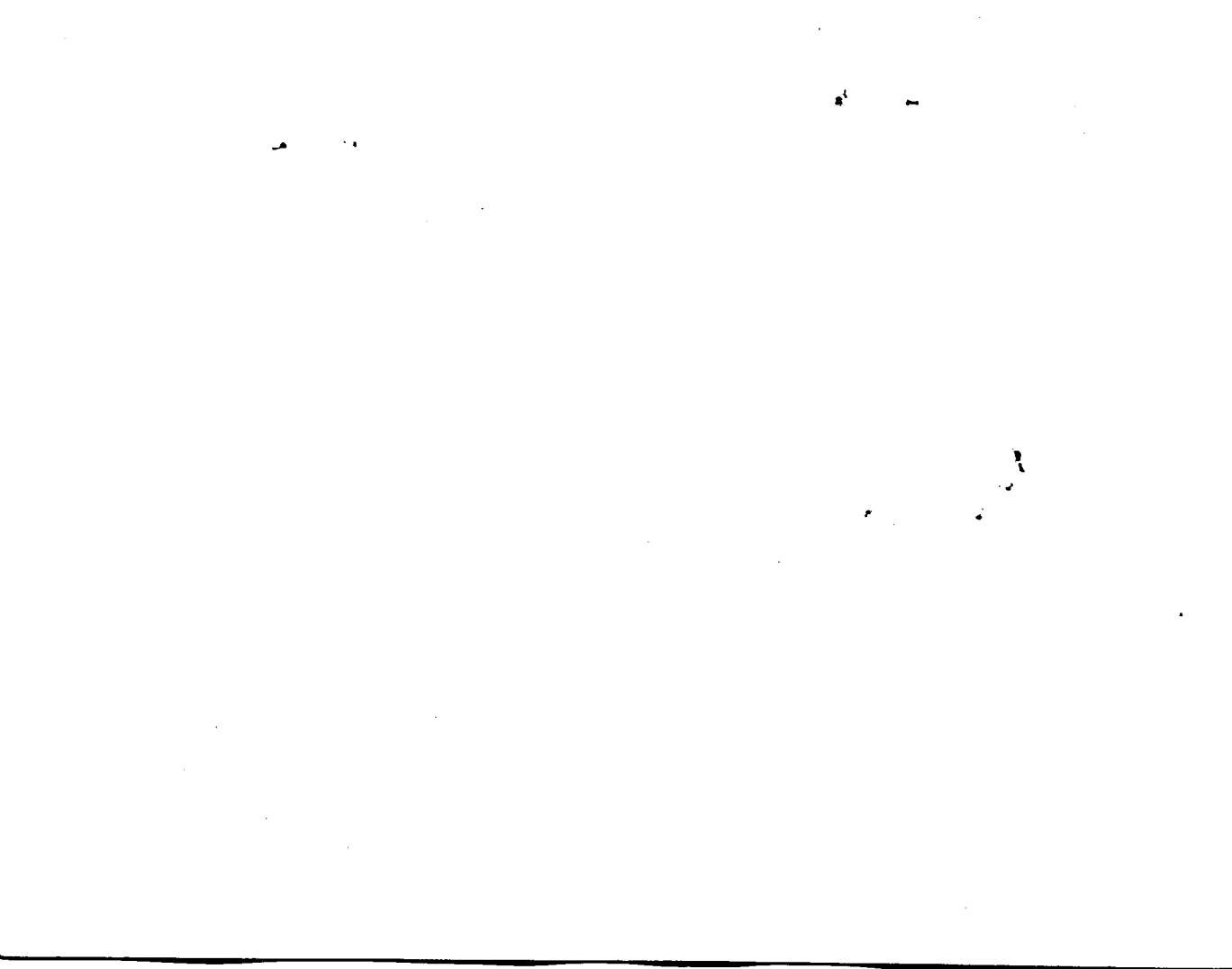
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed 10/21 1929

W. H. Rhodes

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929
 PLACE OF DEATH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67844

County of Ada

City of Boise

Registration District No. 3

Primary Registration District No. 1004

(No. SE Alphonse)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Charles Johnson

(a) Residence. No. Pacific Hotel St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6. DATE OF BIRTH (month, day and year)

Oct 17 - 1929

7. AGE

Years

Months

Days

If LESS than 1 day,
 hrs. or
 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Boise Idaho

10. NAME OF FATHER

Harvey O Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Aileen L. Buchanan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Boise Ida

14.

Informant

(Address)

Harvey O Johnson
Boise Ida

15.

Filed

10-17-1929 W N Rhoads
Boise Ida
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 17 1929
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw him alive on 19____

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* as follows:

Premature still born
 (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) W. J. Coats, M. D.

19____ (Address) ____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Midvale, Ida

10-18 1929

20. Undertaker

Address

Schreiber & N. E. Cann

Boise, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

295-101-001-366
PLACE OF BIRTH

County of Blaine
City of Meridian
No. _____ St. _____

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

175306

Registration District No. _____ State File No. _____

Prim. Registration District No. 2003 Local Registrar's No. 32

FULL NAME OF CHILD

Stillbirth David Kindall
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>8</u> - <u>1</u> - <u>1924</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------------	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 300 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn yes

FATHER FULL NAME <u>Ernest Kindall</u>	MOTHER FULL MAIDEN NAME <u>Mrs. Cooper</u>
---	---

Residence (Usual place of abode) Meridian Residence (Usual place of abode) Meridian

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race white Age at last Birthday 29 Color or race white Age at last Birthday 29
(Years) (Years)

Birthplace Harrison Ark Birthplace Maquokette Mo
(City and State or Country) (City and State or Country)

Occupation Saloon Occupation Supermarket

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6 P. M.
on the date above stated. Stillborn

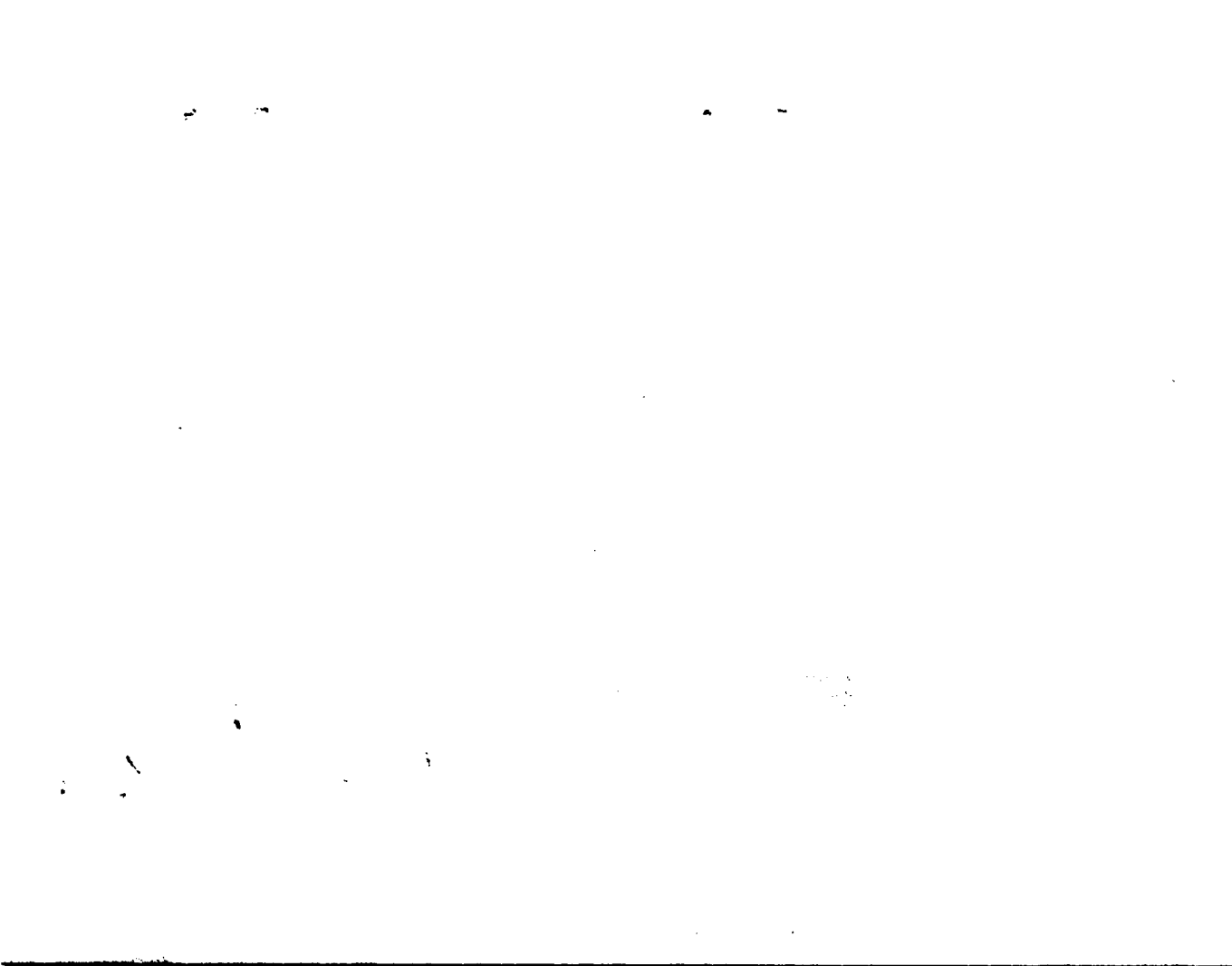
(Signature) Dr. E. Magnuson

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 8-3 1924 HF Neal
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67846

PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No.

Local Registrar's No. 60

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Kendall

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 15 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Meridian
(State or country) Idaho10. NAME OF FATHER Ernest Kendall11. BIRTHPLACE OF FATHER (city or town) Harrison, Ark.
(State or Country)12. MAIDEN NAME OF MOTHER Lucy Cooper13. BIRTHPLACE OF MOTHER (city or town) Meridian City
(State or Country) Idaho

14. Informant Ernest Kendall
(Address) Meridian Idaho

15. Filed Aug 3 1929 J. H. T. M. R.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn Aug 1 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw h. alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of 8-1-29Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos E. Thompson, M. D.Aug 8 1929 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Meridian Idaho 8-2 1929

20. Undertaker Address

E. W. Robinson Meridian Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

712-2091005-796
PLACE OF BIRTH
County of Benewah
City of St. Maries
No. _____ St. _____
Epiph Hospital
(If born in hospital or institution give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 32 State File No. 175382
Prim. Registration District No. 2049 Local Registrar's No. 65

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>10</u> <u>9</u> <u>1929</u> (Month) (Day) (Year)
-----------------------	--	-------	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 2
Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Joseph Gabriel</u> Residence (Usual place of abode) <u>Fernwood</u> If nonresident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>47</u> (Years) Birthplace <u>St. Kansas</u> (City and State or Country) Occupation <u>Engineer</u>	MOTHER FULL MAIDEN NAME <u>Margaret Brown</u> Residence (Usual place of abode) <u>Fernwood</u> If nonresident, give place and State _____ Color or race <u>W</u> Age at last Birthday <u>43</u> (Years) Birthplace <u>Lansing Mich</u> (City and State or Country) Occupation <u>Housewife</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8-10 P. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address St. Maries, Ida

Filed Nov 1st 19 1929 Walter Robert
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

... ..
... ..

AMERICA A BE SUBT-AND COMULATED BEING TOWARD THE B
HIGHER AND STRIKER'S AHEAD IS BIDDING AND NOT MEANS TO WASH ME-ALL M
THESE, ASKED TO WHAT HE WOULD DO TO IMPROVE THE LONG ROAD

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67871

PLACE OF DEATH

County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049

Local Registrar's No. 29

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn(a) Residence. No. St. Maries St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct - 9 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) St. Maries
(State or country) Idaho10. NAME OF FATHER Joseph Gabriel11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)12. MOTHER'S NAME OF MOTHER Margaret Brown13. BIRTHPLACE OF MOTHER (city or town) Lansing
(State or Country) Michigan14. Informant Joseph Gabriel
(Address) St. Maries, Ida15. Filed Nov 12, 1929 Nathan Roberg

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Glaspe

(Signed) _____, M. D.

10/10/, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

St. Maries Oct 10 1929

20. Undertaker

Address

Heath Mitchell St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer,**" etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile,**" etc.), "**Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness,**" etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED ON FILE NOV 8 1929

County of Blaine
City of Sturgeon

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 312-107.006-569 St.

Registration District No. 121

State File No.

175397

(If born in hospital or institution
give name.)

Prim. Registration District No. 1007 Local Registrar's No. 324

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? Yes

Date of
birth Oct 7

(Month)

(Day)

1929

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 100% Ascarol

Number of child of this mother, including present birth. 2

(a) Born alive and now living

Born alive but now dead 0

Stillborn 2

FATHER

FULL
NAME Thorson Casey

Residence (Usual place of abode) Morland

If nonresident, give place and State

Color or race White

Age at last Birthday 25

(Years)

Birthplace Lynnville, Cal.

(City and State or Country)

Occupation Farmer

MOTHER

FULL
MAIDEN
NAME Marine Norrmy

Residence (Usual place of abode) Morland

If nonresident, give place and State

Color or race White

Age at last Birthday 22

(Years)

Birthplace Highland, Idaho

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Sturgeon Id. 9 1 M.
on the date above stated.

(Signature) F. W. Mitchell

(Physician or midwife)

Address 2401 1st St. Sturgeon

Filed Nov 1 1929

M. C. Calver

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

THIS IS A LEGAL DOCUMENT - NOT TO BE USED FOR ANY OTHER PURPOSE
 IN CASE OF DOUBT, CONSULT A LAWYER

OFFICE OF THE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

No. 12-100-12
 (If born in hospital or institution)
 (Date of birth)

Register and District No. 12-100-12
 (If born in hospital or institution)

FULL NAME OF CHILD
 Sex of Child
 Date of Birth
 (Month, Day, Year)

What prophylactic was used to prevent (ophthalmic) neonatal blindness?
 (If none, state "None")

Place of Birth
 (City and State)

Place of Birth
 (City and State)

Place of Birth
 (City and State)

I hereby certify that I attended the birth of this child who was born on the date above stated.

Where there was no attending physician or midwife, then the father or householder should make this return of birth and should state that neither father nor mother had any other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 8 1929

PLACE OF DEATH

County of Bingham
City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 1007(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)2. FULL NAME No. Norm. Casey(a) Residence. No. _____ St. yx

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofTheodore Casey

6 DATE OF BIRTH (month, day and year)

7 AGE Stillborn Years _____ Months _____ Days _____If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓9 BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)10 NAME OF FATHER Theodore Casey11 BIRTHPLACE OF FATHER (city or town) Cal.
(State or country)12 MAIDEN NAME OF MOTHER Maria Norman13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)14 Informant Theodore Casey
(Address) Blackfoot Idaho15 Filed Oct 9 1929 Mr. Walter E. Catie
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 67884Local Registrar's No. 179

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

19 29
(Year)17 Oct. 7 1929, to Oct. 29 1929
I HEREBY CERTIFY, That I attended deceased from
that I last saw him alive on Oct. 29 1929and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

automobile accident
Stillborn. Premature

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? noDid an operation precede death? no Date of ✓Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Mitchell, M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Ranch West of MarslandOct 7 1929

20. Undertaker

Address

No undertaker

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED ON FILE NOV 8 1929

County of Bingham
City of Blackfoot
No. Thomas St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 175298

551-109-006-231
(If born in hospital or institution
give name.)

Registration District No. 121 State File No. 175298
Prim. Registration District No. 2194 Local Registrar's No. 23

FULL NAME OF CHILD Samuel Archie Evans
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 9</u> 1929 (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living none
Born alive but now dead — Stillborn one

FATHER		MOTHER	
FULL NAME <u>William E. Evans</u>	FULL MAIDEN NAME <u>Gladys Statten</u>	FULL NAME <u>Gladys Statten</u>	FULL MAIDEN NAME <u>Gladys Statten</u>
Residence (Usual place of abode) <u>Blackfoot Idaho</u>	Residence (Usual place of abode) <u>Blackfoot Idaho</u>	Residence (Usual place of abode) <u>Blackfoot Idaho</u>	Residence (Usual place of abode) <u>Blackfoot Idaho</u>
If nonresident, give place and State <u>—</u>	If nonresident, give place and State <u>—</u>	If nonresident, give place and State <u>—</u>	If nonresident, give place and State <u>—</u>
Color or race <u>white</u> Age at last Birthday <u>24</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>23</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>23</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>23</u> (Years)
Birthplace <u>Murray Utah</u> (City and State or Country)	Birthplace <u>Niger Idaho</u> (City and State or Country)	Birthplace <u>Niger Idaho</u> (City and State or Country)	Birthplace <u>Niger Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>	Occupation <u>Housewife</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 9. A. M.
on the date above stated. Stillborn }
(Signature) F. C. Mitchell

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot, Idaho
Filed Nov 1 1929 Mrs. Chas. E. Statten
Registrar.

CERTIFICATE OF BIRTH
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE

County of San Diego
 City and Town of San Diego
 No. 251-108-0651
 (To be filled in at hospital or institution)

Registration District San Diego State File No. 251-108-0651
 Local Registration No. 251-108-0651

FULL NAME OF CHILD JOHN WILLIAM

Sex of Child Male
 Date of Birth March 10 1918
 Place of Birth San Diego, California

What prophylactic was used to prevent Opticula in Neonatorum? None
 Name of child of this mother, including present birth None
 Name of father of child None

FATHER JOHN WILLIAM
MOTHER MARY ANN
 Address of child San Diego, California

Signature of John William (Child)
 Signature of Mary Ann (Mother)
 Signature of John William (Father)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who is John William
 on the date above stated.

(Signature) John William
 (Signature) Mary Ann
 (Signature) John William

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, SAN DIEGO, CALIFORNIA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 67520

PLACE OF DEATH

County of BinghamCity of Bluffton

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. B. 194Local Registrar's No. 164

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Archie Evans(a) Residence. No. _____ St. 2nd

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year)

Stillborn

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country)

Bluffton Idaho

10 NAME OF FATHER

William E. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Murray Utah

12 MAIDEN NAME OF MOTHER

Gladys Statten

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Murray Idaho

14

Informant

(Address)

William E. Evans
Bluffton Idaho

15

Filed

Sept 9 1929
Walter E. Patton
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 9
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 1 1929, to Sept 9 1929that I last saw him alive on Sept 9 1929and that death occurred, on the date stated above, at 9.41 m.

The CAUSE OF DEATH* was as follows:

Birth. Premature 7 mo.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

Overwork of mother

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

H. W. Mitchell9/9

1929

(Address)

Bluffton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Thomas Ann.

19

20. Undertaker

Address

W. E. Evans

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

819-213014-368
PLACE OF BIRTH
RECEIVED NOV 13 1929
County of Canyon
City of Caldwell
No. # 1 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

175458

Registration District No. 3 State File No. 175458
Prim. Registration District No. 2005 Local Registrar's No. 189

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>10/13</u> (Month) (Day) (Year) <u>1929</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME John Eugene Harritt
R. # 1, Caldwell, Idaho
Residence (Usual place of abode) _____
If nonresident, give place and State _____
Color or race White Age at last Birthday 27
Idaho (Years)
Birthplace _____
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Laura E. Loy
1, Caldwell, Idaho
Residence (Usual place of abode) _____
If nonresident, give place and State _____
Color or race White Age at last Birthday 18
Ill (Years)
Birthplace _____
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ M.
on the date above stated.

(Signature) S. B. Dudley
M. D.
(Physician or midwife)

Address Caldwell, Idaho

Filed 10-14-1929 John B. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

CHOCOLATE TRUFFLES. A CHOCOLATE-MILK DISC, COATED WITH CHOCOLATE, AND FILLING WITH VANILLA CREAM, IS THE PERFECT TREAT FOR THE CHOCOLATE LOVER. TO MAKE 12 TRUFFLES, MELT 1/2 CUP CHOCOLATE AND 1/4 CUP MILK IN A DOUBLE BOILER. STIR UNTIL SMOOTH. ADD 1/4 CUP VANILLA EXTRACT AND 1/4 CUP SUGAR. STIR UNTIL COOL. ROLL INTO BALLS. COAT WITH CHOCOLATE. LET SET.

LIST NAME OF CHITS

(If you are removed or expelled)

Registration District No. 1 State of New York

Train Registration Number: 10-10-10-10-10

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

19 000 000

What, specifically, was used to prevent the flight instructor from flying?

[illegible]

9-1706

INCHAM

INCHAM

... to

10-10-68

Page 1 of 1

100-443887-100

CONFIDENTIAL - ATTENDING PHYSICIAN ONLY

I hereby certify that I attended the birth of this child, who was born on the date above stated.

10/11/12)

[illegible]

52914A

4-10-1964

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 13 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **67936**

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 109

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Harriett
(a) Residence. No. Caldwell, Idaho, Rm. 1-St.
(Usual place of abode)
Length of residence in city or town where death occurred. — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 13 - 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or 13 mos.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell (State or country) Ida
10. NAME OF FATHER J E Harriett
11. BIRTHPLACE OF FATHER (city or town) Meridian (State or Country) Ida
12. MAIDEN NAME OF MOTHER Laura Lay
13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country) Ida

14. Informant J E Harriett
(Address)

15. Filed 10-19- 1929. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 13 - 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1929, to Oct 13 1929
that I last saw her alive on Oct 13 1929
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Still born
a defective development
Cranium
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J E Harriett, M. D.
Oct 14 1929 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal at home Date of Burial 10-13-1929

20. Undertaker Kathie E. Friend Address Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

594-12401-219
RECEIVED NOV 18 1929

County of Canyon
City of Tramby
No. Mcley Street

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 175482

Registration District No. 7 State File No. 175482
Prim. Registration District No. 1000 Local Registrar's No. 242
(If born in hospital or institution give name.)
FULL NAME OF CHILD Johnathan
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <u>Triplet</u> or other? <u>and</u> { } Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Oct 24</u> 19 <u>29</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum? Mer. Libal
Number of child of this mother, including present birth 3 (a) Born alive and now living 2
Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Thomas Raymond Edde</u>	FULL MAIDEN NAME <u>Martha Edith Barr</u>	Residence (Usual place of abode) <u>Tramby, Ida</u>	Residence (Usual place of abode) <u>Tramby, Ida</u>
It non-resident, give place and State <u>Idaho</u>	It non-resident, give place and State <u>Idaho</u>	Color or race <u>W</u> Age at last Birthday <u>33</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>34</u> (Years)
Birthplace <u>Idaho</u> (City and State of County)	Birthplace <u>Idaho</u> (City and State or County)	Occupation <u>farmer</u>	Occupation <u>farmer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:40 A. M.
on the date above stated.

(Signature) Samuel D. Swannell
(Physician or midwife)

Address Tramby, Ida
Filed 11-11 1929 Beulah Conway
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67915

PLACE OF DEATH
County of Lampson
City of Nampa

Registration District No. 7Primary Registration District No. 1006Local Registrar's No. 111(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant son of Mr + Mrs L. R. Edde 706(a) Residence. No. 16 - So East of Nampa

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) None

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Oct 24 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
✓ ✓ ✓ ✓ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa Idaho
(State or country)10. NAME OF FATHER Mr R. Edde11. BIRTHPLACE OF FATHER (city or town) Norton
(State or Country)12. MAIDEN NAME OF MOTHER Mrs. Edith Bay13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant JR Edde
(Address) 716 Locust St15. Filed 10-28, 1929 Beth Combs
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 24 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1929, to Oct. 24, 1929

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Asphyxiation due to
prolapsed cord.

(duration) _____ yrs. mos. ds.

CONTRIBUTORY Samuel A. Swayze, M.D.
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Samuel A. Swayze, M.D.Oct. 28 1929 (Address) Nampa, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Mark's Cemetery Date of Burial Oct 24 1929

20. Undertaker Fred & A. Finney Address Nampa

(Carry over.)

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695-212-218-959
PLACE OF BIRTH
RECEIVED NOV 6 1929
County of Clearwater
City of Orofino
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 175526

Registration District No. 90 State File No. _____

Prim. Registration District No. 2187 Local Registrar's No. 76

FULL NAME OF CHILD Baby Not Named

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins or other? <u>and</u> { } and { } Triplet or other? { } (To be answered only in event of plural births)	Number in order of birth { } (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Oct 17 1929</u> (Month) (Day) (Year)
----------------------------	--	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn One

FATHER	MOTHER
FULL NAME <u>Arthur Trear</u>	FULL MAIDEN NAME <u>Angis Reid</u>
Residence (Usual place of abode) <u>Grangemont Ida</u>	Residence (Usual place of abode) <u>Grangemont Ida</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>white</u> Age at last Birthday <u>34</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>41</u> (Years)
Birthplace <u>Missouri</u> (City and State or Country)	Birthplace <u>Wisc</u> (City and State or Country)
Occupation <u>Truck Driver</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 8:30 a. M.
on the date above stated.

(Signature) R. J. Stoplewis

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed Oct 18 1929 W. C. Khan

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67955

County of Clearwater

Registration District No. 90

City of Orofino

Primary Registration District No. 2187

Local Registrar's No. 104

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Not Named

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 17 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Orofino Ida
(State or country)

10. NAME OF FATHER

Arthur Frear

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Angie Reid

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Wis

14. Informant Arthur Frear
(Address) Grandmont, Ia

15. Filed Oct 18, 1929 W. A. Chan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis of mother
Tuberculosis (duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? P. J. Hopkins, M. D.
(Signed) 10/17, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Weasman Cemetery

Oct 18 19

20. Undertaker

Address

W. A. Chan

Orofino

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

33-117029-263
PLACE OF BIRTH
RECEIVED NOV 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

175658

County of Latah

City of Moscow

No. 1st & Jackson St.

Registration District No. 61

File No.

Hospital Indian Empire

Primary Registration District No. 1011

Registered No. 112

FULL NAME OF CHILD Robert Snilton Clark

(Certificate of no value without full name of child.)

Sex of Child

M

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Oct 17

1929

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. 0

FULL
NAME

FATHER
Herbert Strickland Clark

FULL
MAIDEN
NAME

MOTHER
Onabel Ruth Bolte

RESIDENCE

Moscow, Idaho

RESIDENCE

Moscow, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

22
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

23
(Years)

BIRTHPLACE

Minn.

BIRTHPLACE

Kan.

OCCUPATION

Student

OCCUPATION

Hwp.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

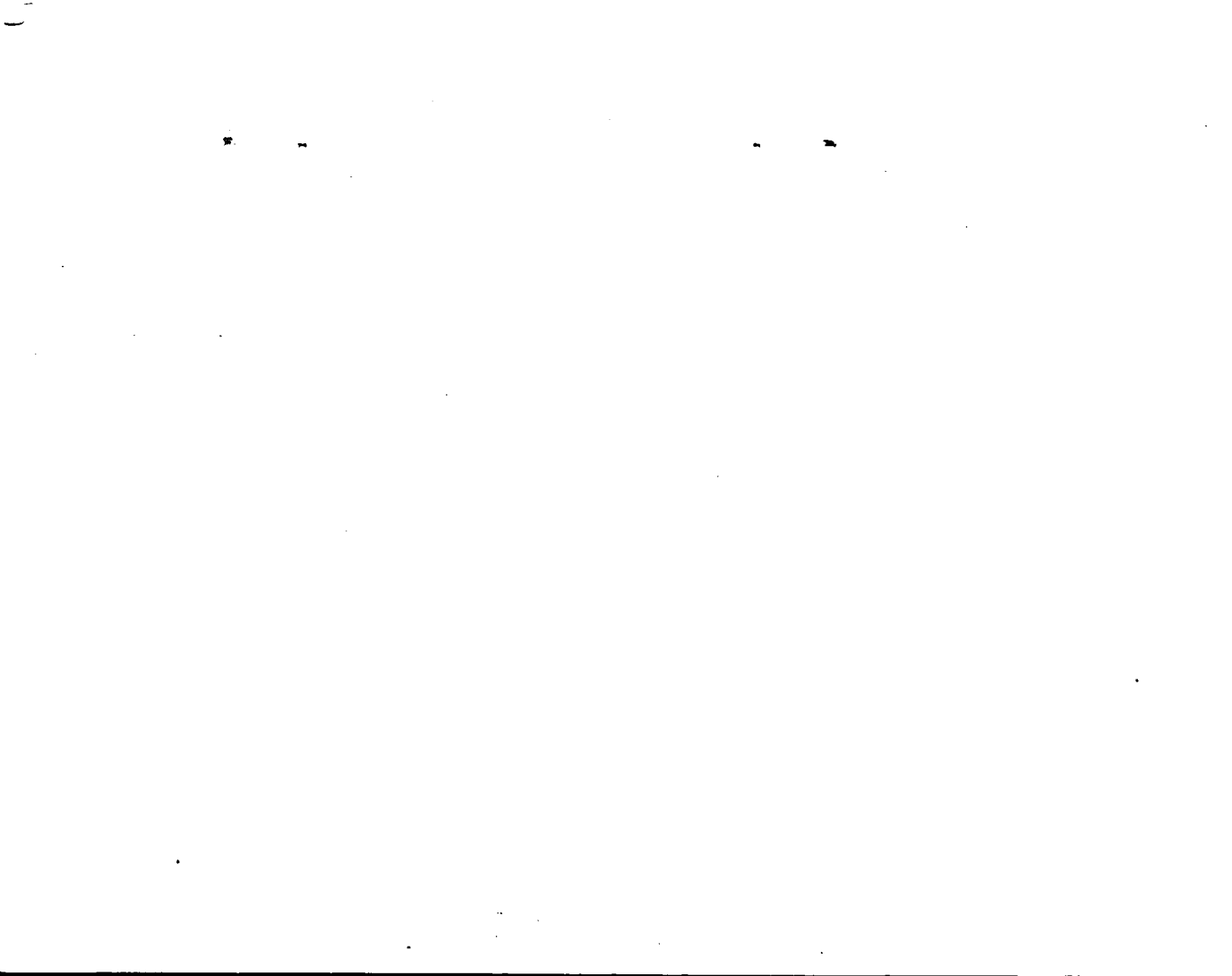
(Signature)

Stillborn 9⁴⁵ P M.
Dr. Magee
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Filed Oct 18 1929 W. H. Caruthers
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 9 1929
Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 101

County of Idaho

Primary Registration District No. 1011

City of Moscow

(No. Inland Hospital St.)

File No. 67996

Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Milton Clark

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

White

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

October 16

1929

(Month)

(Day)

(Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Moscow, Idaho

10. NAME OF FATHER

Herbert S. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Mabel Bolte

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert S. Clark

(Address) Moscow Ida.

15.

Filed Dec 17 19129

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 16

1929

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

during delivery, to 191

that I last saw h alive on 191

and that death occurred on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Defect of Occipital bone

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. Mager M. D.

10/17 1929 (Address) Moscow

"State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

10/17/29 19129

20. UNDERTAKER

ADDRESS

Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

386-223-236-165
PLACE RECEIVED

NOV 7 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Oneida
City of Malad
No. St.

CERTIFICATE OF BIRTH

Registration District No. 26 State File No. S 175820

Prim. Registration District No. 2069 Local Registrar's No. 123

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Oct. 23</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Melvin Thompson

Residence (Usual place of abode) Malad, Ida

If nonresident, give place and State ✓

Color or race White Age at last Birthday 26 (Years)

Birthplace Loose, Idaho
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Mary W. Jones

Residence (Usual place of abode) Malad, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 23 (Years)

Birthplace Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12.30 P. M.
on the date above stated.

(Signature) V. O. Garst

(Physician or midwife)

Address Malad, Idaho

Filed 10-31 1929 J. H. Kern

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

STATE OF ILLINOIS
 COUNTY OF COOK
 CITY OF CHICAGO
 I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the child named above was born to the mother named above on the day and date above stated, and that the child is a legitimate child of the mother named above.

and that there was no attending physician or midwife present at the birth of the child named above, and that the father named above is the father of the child named above, and that the mother named above is the mother of the child named above, and that the child named above is a legitimate child of the mother named above.

Signature of midwife

(Signature)

I hereby certify that I attended the birth of this child, who was (Name of child) on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

City and State of Country

Age at last birthday

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

It is not stated (Place of birth)

MARGIN RESERVED FOR MEDICAL CERTIFICATE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68063

County of Quincy
City of Malad

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 30

(No. _____)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Malad Id St. Thompson

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced, (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Malad Id

10. NAME OF FATHER Melvin Thompson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boyle Wm

12. MAIDEN NAME OF MOTHER Mary H. Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Melvin Thompson
(Address) Malad Id

15. Filed 10-31-29 J.M. Kerns
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 23 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 to Oct 23 19 29
that I last saw in bed alive on Oct 23 19 29
and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH was as follows:

Extreme heart disease
regarding heart undetected

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) U. O. Gant M. D.
Oct 23 19 29 (Address) Malad Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Id Date of Burial 10-24-29

20. Undertaker Parents Address Malad Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

955-229,236-291
PLACE OF BIRTH

County of Blaine
City of Malad
No. _____ St. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD _____

Registration District No. 46 State File No. 175823

Prim. Registration District No. 2069 Local Registrar's No. 176

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins or other? <u>None</u>	Number in order of birth <u>1</u>	Legitimate <u>Yes</u>	Date of birth <u>Oct. 29</u> 19 <u>29</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 7th (a) Born alive and now living 5

Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Philip M. Rees
Residence (Usual place of abode) Malad R. 70 #2
If nonresident, give place and State C
Color or race White Age at last Birthday 49
Birthplace Cherry Creek Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Nellie Brantger
Residence (Usual place of abode) Malad R. 70 #2
If nonresident, give place and State C
Color or race White Age at last Birthday 44
Birthplace Montana, Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:30 P. M.
on the date above stated.

(Signature) V. P. Sarst

(Physician or midwife)

Address Malad Idaho

Filed 10/31 1929 J. M. Kerns

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS A CERTIFICATE OF BIRTH
 IN CASE OF DEATH OF CHILD
 IN CASE OF DEATH OF CHILD
 IN CASE OF DEATH OF CHILD

PLATE NO. _____

CERTIFICATE OF BIRTH

County of _____ State of _____

Registration District No. _____

Local Registrar No. _____

NAME OF CHILD _____

Sex of Child _____

Date of Birth _____

Legitimacy _____

Place of Birth _____

Parents' names _____

Occupation _____

Address _____

Signature _____

Witness _____

Registrar _____

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Malad* NOV 7 1929Registration District No. *2069*County of *Malad*Primary Registration District No. *2069*City of *Malad*

(No. _____ St.)

File No. *65062*Registered No. *31*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Still born*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Child*6. DATE OF BIRTH *Oct. 29 1929*7. AGE *0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many *0* hrs.
or *0* min.?8. OCCUPATION *Child*(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE *Malad Ida R. I. O. #2*

(State or Country)

10. NAME OF FATHER *Phillips M. Reese*11. BIRTHPLACE OF FATHER *Idaho*

(State or Country)

12. MAIDEN NAME OF MOTHER *Mellie Kuntz*13. BIRTHPLACE OF MOTHER *Utah*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Philip M. Reese*

(Address)

15.

Filed *10-31* 19*29*Local Registrar *J. M. Kuntz*16. DATE OF DEATH *Oct. 29 1929*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct. 29 1929* to *19*that I last saw him *alive on* *19*and that death occurred on the date stated above, at *Room 130 A, M.*

The CAUSE OF DEATH* was as follows:

Still born.
(Cause unknown)
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *V. J. Gant* M. D.(Address) *Malad, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Malad Ida*DATE OF BURIAL *Oct. 29 1929*20. UNDERTAKER *J. Guy Benson*ADDRESS *Malad Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

795-119-040 238
PLACE OF BIRTH
RECEIVED NOV 6 1929
County of Shoshone
City of Kellogg
No. _____ St. _____ Registration District No. 123 State File No. 175853
Hospital _____ Primary Registration District No. 2201 Local Registrar's No. 122

CERTIFICATE OF BIRTH

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>9-19-1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER FULL NAME <u>A. V. Jr. Gregg</u>		MOTHER FULL MAIDEN NAME <u>Anne Schneider</u>	
RESIDENCE <u>Kellogg, Ida</u>		RESIDENCE <u>Kellogg, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Independence, Kan</u>		BIRTHPLACE <u>Butte, Mont.</u>	
OCCUPATION <u>Cafe</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1929

(Signature) _____

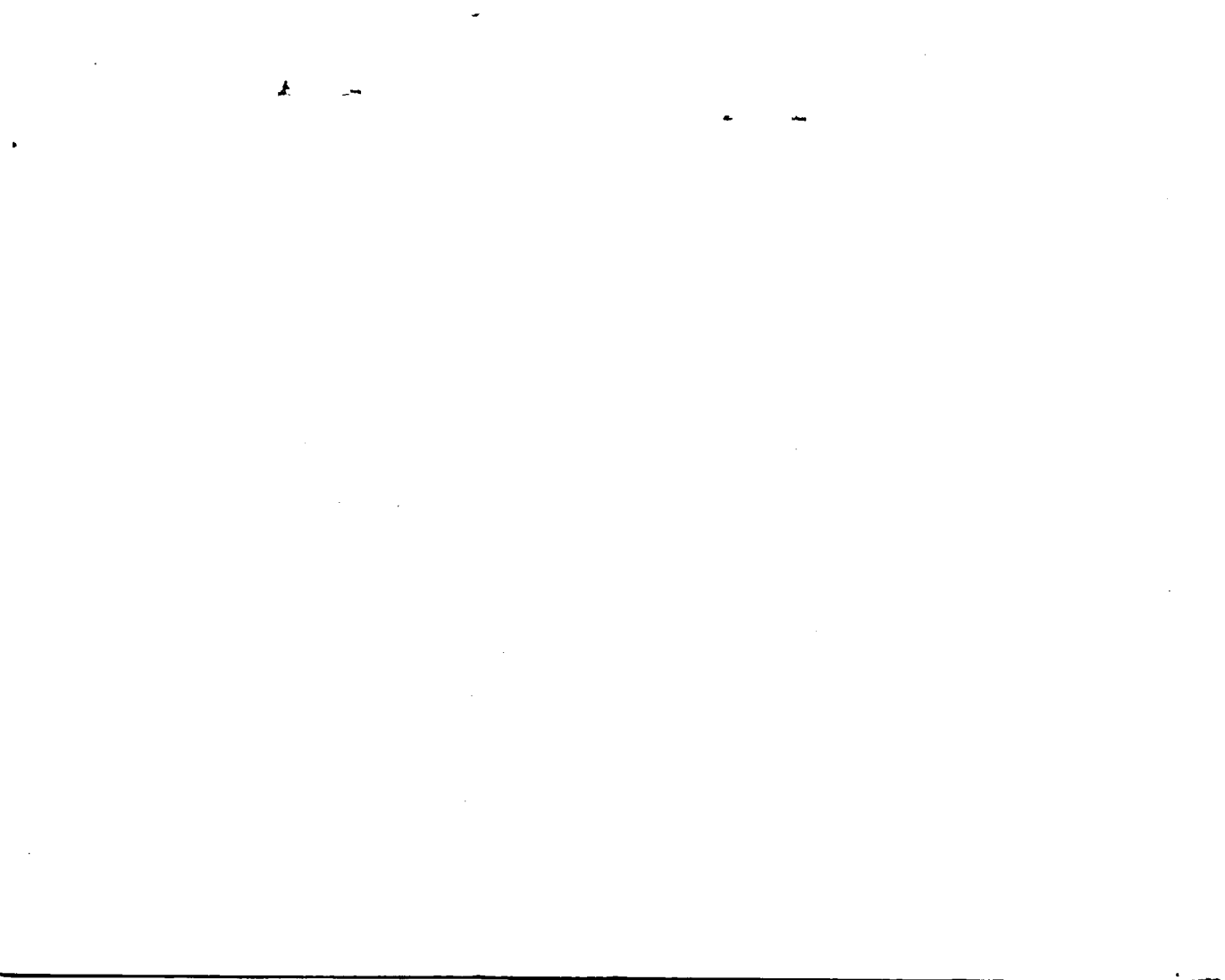
(Physician or midwife)

Address _____

Filed Oct. 30 1929

Registrar.

Registrar.



RECEIVED OCT 7 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 67699

County of Kellogg

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 44

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME A. V. Jr. Greer

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19-29

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Idaho (State or country)

10. NAME OF FATHER A. V. Greer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Independence Kansas

12. MAIDEN NAME OF MOTHER Anna Schneider

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butte Montana

14. Informant Anna Greer (Address) Kellogg Idaho

15. Filed Sept. 30, 1929 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 19 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-19-1929

that I last saw him alive on 19

and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH* was as follows:

(Stillbirth)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. A. ... M. D. 9-28-1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg - Date of Burial Sept. 30 1929

20. Undertaker R. A. Clout Address Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

33-163-242-753
PLACE OF BIRTH
RECEIVED OCT 23 1929

County of _____
City of _____
No. _____ St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 39 State File No. 175931

Prim. Registration District No. 2087 Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>2</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>3-Sept-</u> <u>1929</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Raymond F. Clayton
Residence (Usual place of abode) Buhl, Ida
If nonresident, give place and State _____

MOTHER
FULL MAIDEN NAME Delora Peterson
Residence (Usual place of abode) Buhl, Ida
If nonresident, give place and State _____

Color or race White Age at last Birthday 27 (Years)
Birthplace Creede, Colorado
(City and State or Country)
Occupation Farmer

Color or race White Age at last Birthday 23 (Years)
Birthplace Esphraim, Utah
(City and State or Country)
Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Relative } at 10 P. M.
on the date above stated. { Stillborn }

(Signature) J. W. MacMann

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 9-5 1929 J. H. Murphy
Registrar.

Prenatal & malposition - both arms protruding

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

313-221-042-319
PLACE OF BIRTH
RECEIVED NOV 6 1929
County of Boise
City of Buhl
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

175935

Registration District No. 39 State File No. _____

Prim. Registration District No. 2087 Local Registrar's No. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>4.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>10</u> <u>21</u> <u>1929</u> (Month) (Day) (Year)
---------------------------	---	-------	---	--------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? arsenal

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 2 Stillborn _____

FATHER FULL NAME <u>W. B. Calhoun</u> Residence (Usual place of abode) <u>Buhl</u> If nonresident, give place and State _____ Color or race <u>W.</u> Age at last Birthday <u>33</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>auto mechanic</u>	MOTHER FULL MAIDEN NAME <u>Dorilla Canabau</u> Residence (Usual place of abode) <u>same</u> If nonresident, give place and State _____ Color or race <u>W.</u> Age at last Birthday <u>30</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>housewife</u>
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 a. M.
on the date above stated.

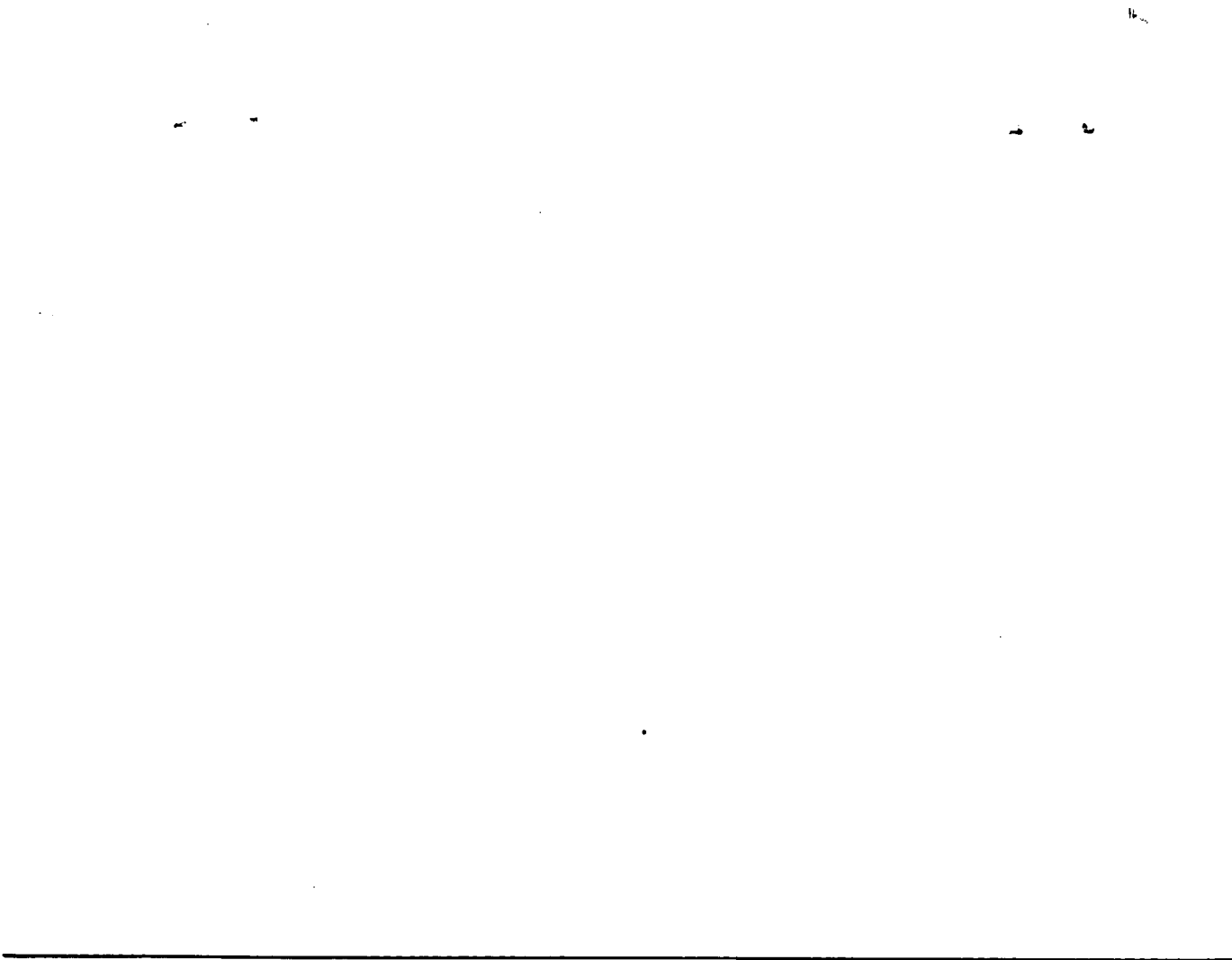
(Signature) J. T. Murphy

(Physician or midwife)

Address Buhl Ida.

Filed 10 31 1929 J. T. Murphy
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68122

PLACE OF DEATH
County of Latah
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No. 206

(No. _____)
(If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day.
✓ ✓ ✓ _____ hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9. BIRTHPLACE (city or town) Buhl, Ida.
(State or country)

10. NAME OF FATHER Marcus Calhoun

11. BIRTHPLACE OF FATHER (city or town) Austin, Ark.
(State or Country)

12. MAIDEN NAME OF MOTHER Annella Carnahan

13. BIRTHPLACE OF MOTHER (city or town) So. Dakota
(State or Country)

14. Informant Marcus Calhoun
(Address) Buhl, Ida.

15. Filed 10-21, 1929 J. H. Wampler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 21, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929 to _____, 19____
that I last saw him still born, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Hydrocephalus.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? no.

What test confirmed diagnosis? _____

(Signed) J. H. Wampler, M. D.

10-21, 1929 (Address) Buhl.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl, Ida. Date of Burial 10/21, 1929

20. Undertaker L. E. Emsau Address Buhl, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

625-126-092 27
PLACE OF BIRTH
County of Twin Falls NOV 9 1929
City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 175953

No. St.

T. F. Co. 9 year
(If born in hospital or institution
give name.)

Registration District No. 37 State File No.

Prim. Registration District No. 2485 Local Registrar's No.

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 26</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER

FULL NAME Frank Oseletto

Residence (Usual place of abode) Buhl Idaho

If nonresident, give place and State

Color or race W Age at last Birthday 26 (Years)

Birthplace Bingham Co. Utah
(City and State or Country)

Occupation Fireman

MOTHER

FULL MAIDEN NAME Mary Ellen Bagshaw

Residence (Usual place of abode) Buhl Idaho

If nonresident, give place and State

Color or race W Age at last Birthday 26 (Years)

Birthplace England
(City and State or Country)

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 5:15 A. M.
on the date above stated. { Stillborn }

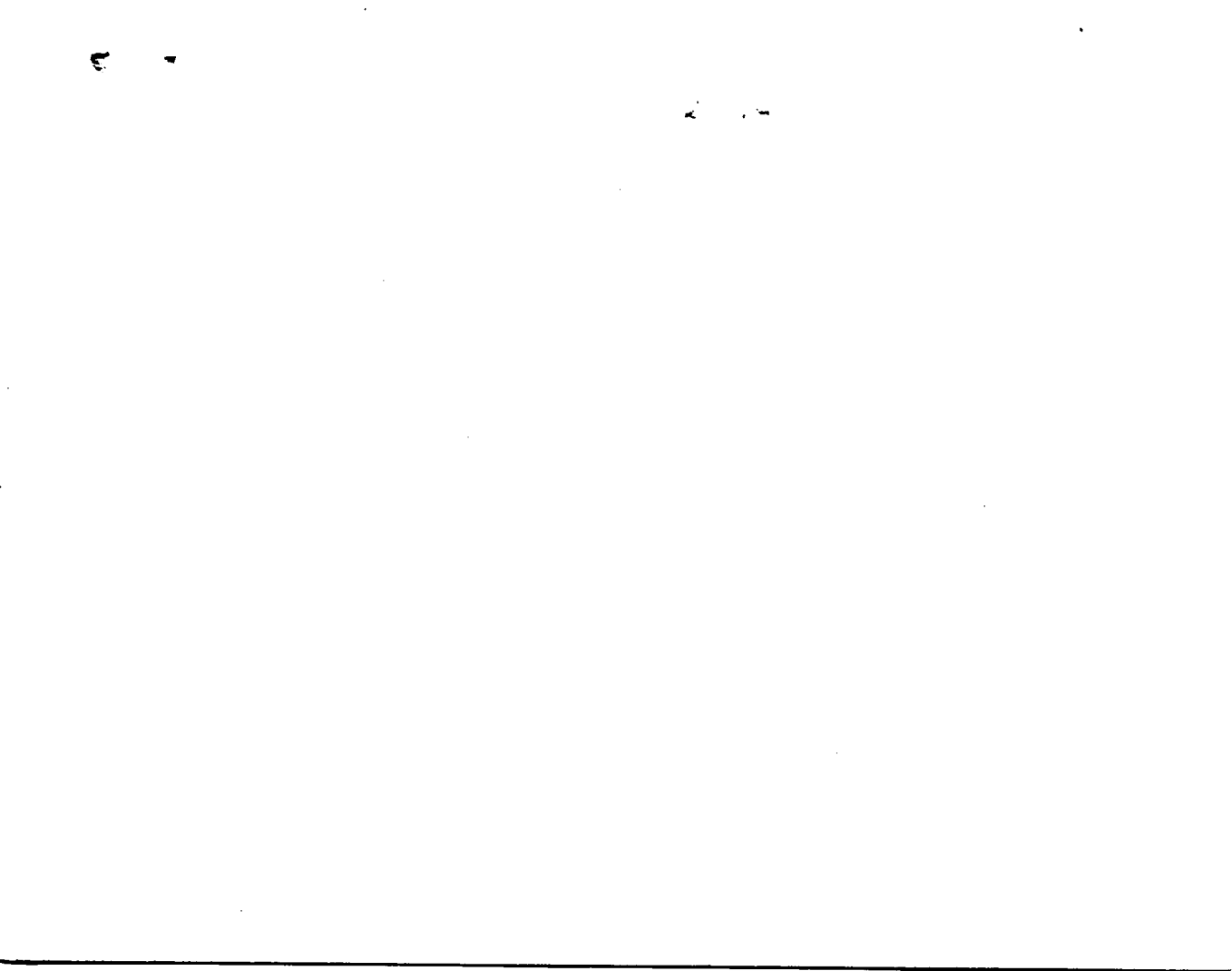
(Signature) Bo Janning

(Physician or midwife)

Address Buhl, Ida.

Filed 11-6 1929 D. D. M. Couper
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



Which Philosophy for from Talks

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. All diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

664-202-2291
PLACE RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Ada
City of Boise

No. 175 St.

St. Lukes Hospital

(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 176021

Prim. Registration District No. 1004 Local Registrar's No. 451

FULL NAME OF CHILD Lavenna Mae Fowler

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 2</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 2.0% argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living none

Born alive but now dead none Stillborn 1

FATHER
FULL NAME Vern J. Fowler

Residence (Usual place of abode) Boise Idaho

If non-resident, give place and State

Color or race W Age at last Birthday 43 (Years)

Birthplace Alberta Canada
(City and State or County)

Occupation Lawman

MOTHER
FULL MAIDEN NAME Alta Mae Bransfield

Residence (Usual place of abode) Boise Idaho

If non-resident, give place and State

Color or race W Age at last Birthday 22 (Years)

Birthplace Douds Iowa
(City and State or County)

Occupation SH W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 2:20 A M.
on the date above stated.

(Signature) W. Callaway-Joplin
Physician
(Physician or midwife)

Address Boise Idaho

Filed 11-19 1929 W. N. Rhodes
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

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125 WEST 4TH STREET
NEW YORK, N. Y.

(422)

(This is not a "BIB" row and should not be used)

(continued from page 10)

Number 1 child of this group, including present birth date and now living

RECEIVED
JAN 10 1964
U.S. AIR FORCE

.....

(10-1)

CONFIDENTIAL - NO DISSEMINATION TO BE ALLOWED

JA

shows other evidence of the latter's child is one that neither brother nor sister should make this return. A child or, in other words, the father, should be reported as the father of the child.

176021 ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instruction on back of certificate.

Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

79-212-88-651
PLACE OF BIRTH
RECEIVED
DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Ada

City of Boise

No. _____ St. _____ Registration District No. 2 State File No. 176031

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 481

FULL NAME OF CHILD — not named — Premature Stillbirth
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth Legitimate? yes Date of birth Nov. 19 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? — none — stillborn

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth

FATHER
FULL NAME Stewart J. Gray
RESIDENCE 140 Main - Boise Ida
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Antigo, Wisconsin
OCCUPATION Salesman

MOTHER
FULL MAIDEN NAME Blady's May Weaver
RESIDENCE 140 Main - Boise -
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Chadron, Neb.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P.M. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1929

(Signature) H. E. Dedman M.D.

(Physician or midwife)

Address Boise, Idaho

Filed 11-26 1929 W. H. Rhodes
R. S. Registrar.

Registrar.

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

DEC 8 1923

Give names added from a supplemental report.
128

Address

Filed 11-24-23

(Physician's certificate)

Handwritten signatures and notes at the bottom of the page.

RECEIVED DEC 6, 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68151

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 277

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 140 Main St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OF RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

11-19-29

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Boise

10. NAME OF FATHER

Steward J. Gray

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Wisconsin

12. MOTHER'S NAME OF MOTHER

Helen Rose

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Chadron, Neb.

14. Informant

(Address)

Steward J. Gray

15. Filed

11-21, 1929

W. H. Rhodes

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw him alive on, 19

and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Premature Stillbirth - umbilical cord
coiled tightly about neck,
twice

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)Premature rupture of
membranes

(duration) yrs. mos. 3 ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

H. E. Hedman M. D.

Nov. 20, 1929 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Marion Hill Cemetery 11/21 1929

20. Undertaker

Address

Schnecker & W. H. Baum Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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* unknown.

Registrars should be careful to see that the medical

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Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

248-112-003-863
PLACE OF BIRTH

County of San Juan NOV 21 1929
City of Pocahontas

No. _____ St. _____

Poc. Gen. Hosp.
(If born in hospital or institution give name.)

Registration District No. 28 State File No. 176046

Prim. Registration District No. 2161 Local Registrar's No. 9484

FULL NAME OF CHILD Stillbirth Kuhn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <u>—</u> Triplet <u>—</u> or other? <u>—</u>	and { Number in order of birth <u>—</u> }	Legitimate <u>yes</u>	Date of birth <u>Oct. 12</u> 19 <u>29</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Walter Celigman Kuhn

Residence (Usual place of abode) Pocahontas

If nonresident, give place and State _____

Color or race white Age at last Birthday 38 (Years)

Birthplace Ogden Utah (City and State or Country)

Occupation merchant

MOTHER
FULL MAIDEN NAME Gottie Mae Holmes

Residence (Usual place of abode) Pocahontas

If nonresident, give place and State _____

Color or race white Age at last Birthday 43 (Years)

Birthplace Calif. (City and State or Country)

Occupation house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 2 P. M.
on the date above stated.

(Signature) W. R. Brothers

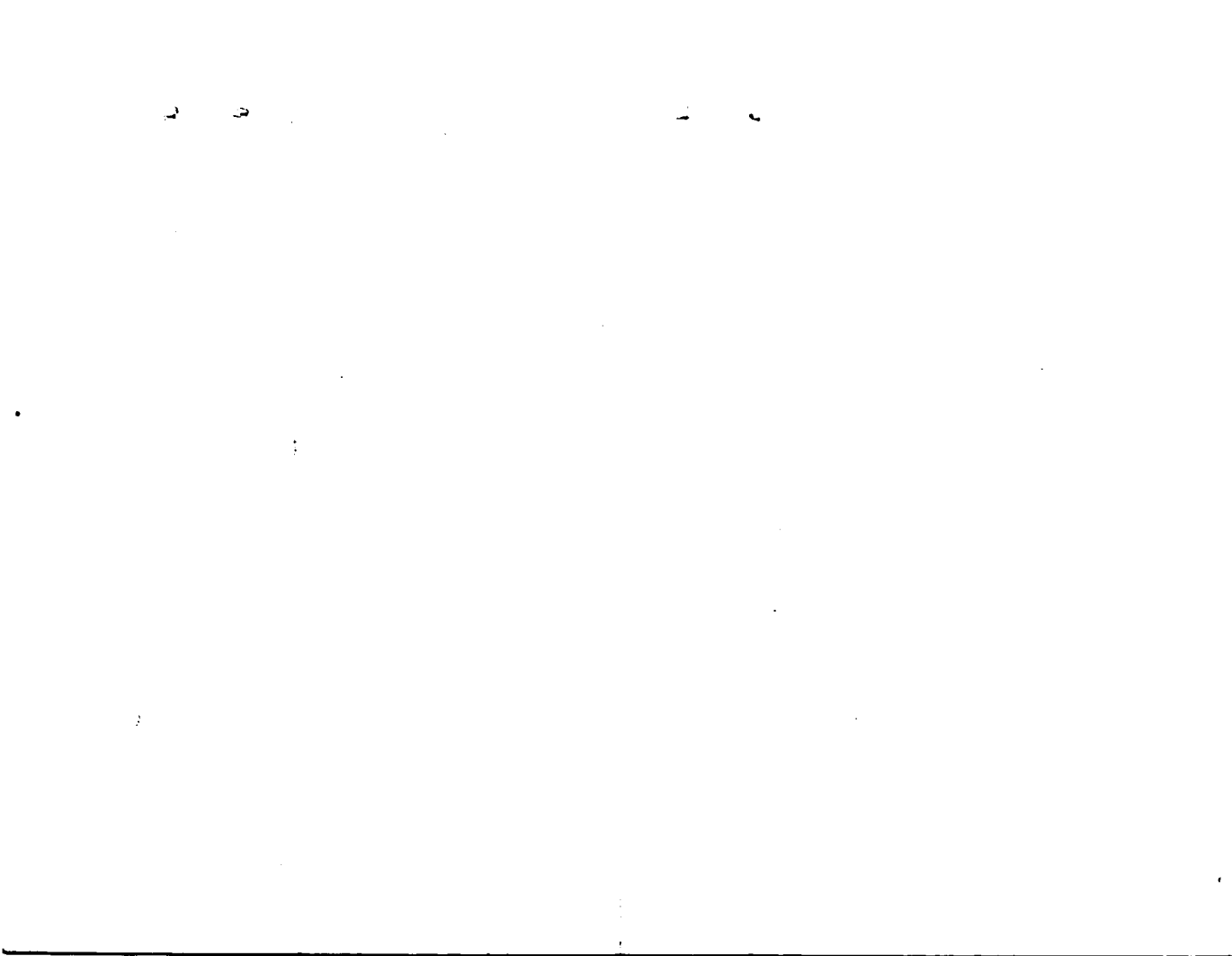
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Pocahontas

Filed 11/1 1929

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68198

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28Primary Registration District No. 2161Local Registrar's No. 6788

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant W. S. Kuhn(a) Residence. No. Head apt St. 204(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Oct 12th

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country)10. NAME OF FATHER W. S. Kuhn11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah12. MAIDEN NAME OF MOTHER Lathem Holmes13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Cal14. Informant W. S. Kuhn
(Address) Pocatello Id15. Filled 10/18, 1929

W. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-12, 1929, to 10-12, 1929

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY High forceps delivery
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Brothers, M. D.10-18, 1929 (Address) PocatelloIdaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

mt View 10/13 1929

20. Undertaker

Address

Schumacher & Beach City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

294-12-15-23-5-43
PEACE OF BIRTH NOV 5 1929

County of Bannock
City of Grace
No. 4 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. 176071

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child 1 Boy Twin Triplet or other? _____ and { Number in order of birth _____ } Legiti- leg Date of birth Oct 27 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 0

Born alive but now dead no Stillborn 3

FATHER
FULL NAME Alma Simonson

Residence (Usual place of abode) Grace, Ida.

If nonresident, give place and State _____

Color or race American Age at last Birthday 37 (Years)

Birthplace Brigham City Utah
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Sarah Hutchison

Residence (Usual place of abode) Grace, Ida.

If nonresident, give place and State _____

Color or race American Age at last Birthday 37 (Years)

Birthplace Wellsville, Utah
(City and State or Country)

Occupation Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

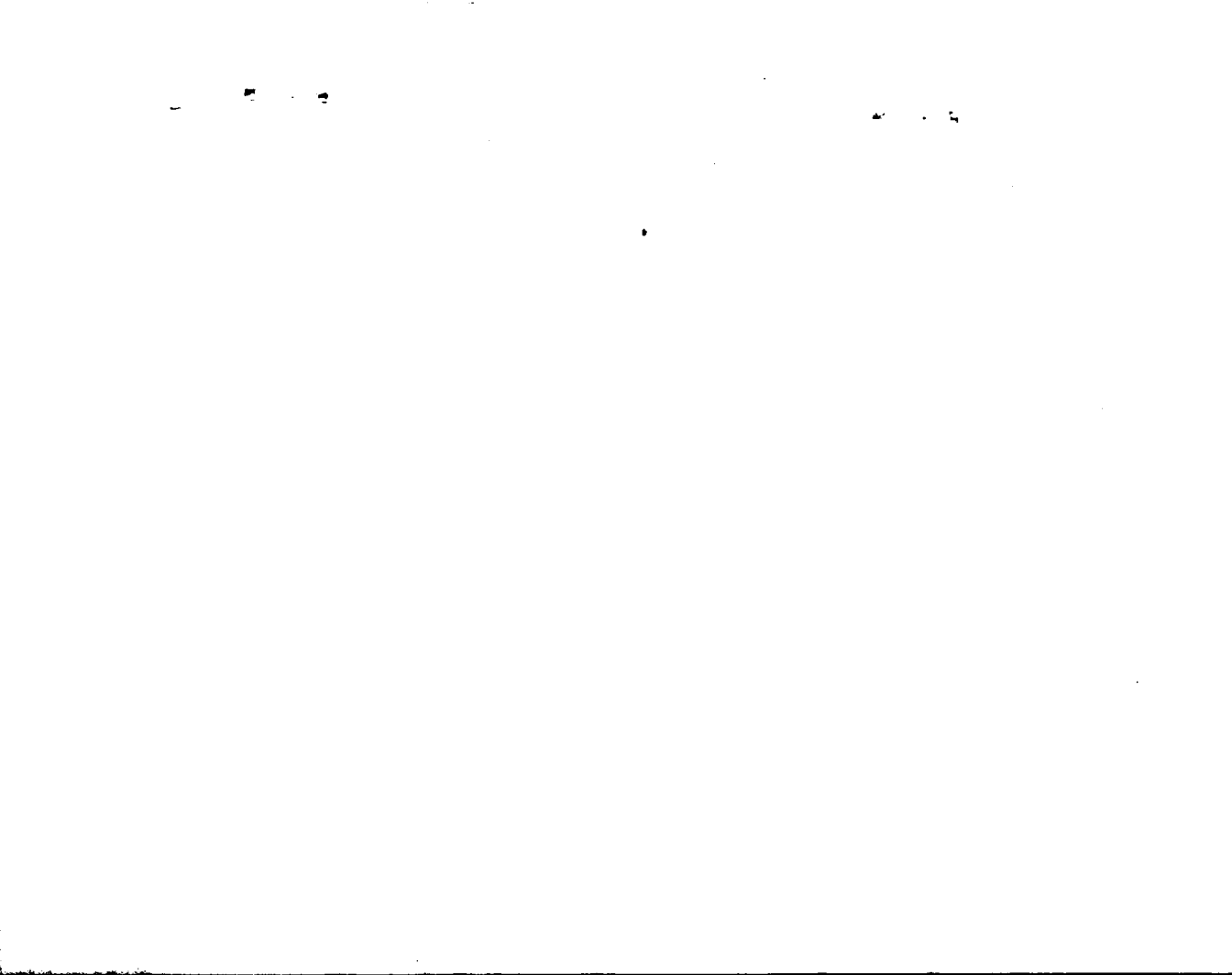
I hereby certify that I attended the birth of this child, who was { Born alive } at _____ M.
on the date above stated. { Stillborn }

(Signature) _____

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Soda Springs, Ida.

Filed Nov. 25 1929 B. A. Macey
State _____ Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. RECORD N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

68171

State File No.

Local Registrar's No.

PLACE OF DEATH
County of Bannock
City of Grace

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. Grace St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Boy 4 COLOR OR RACE American 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Grace, Ida.
(State or country)

10 NAME OF FATHER Alma Simonson

11 BIRTHPLACE OF FATHER (city or town) Brigham City Utah
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hutchison

13 BIRTHPLACE OF MOTHER (city or town) Wellsville Utah
(State or country)

14 Informant
(Address)

15 Filed Nov 25 1929 CH Macey Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Oct 27 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
_____, 19_____, to _____, 19_____,
that I last saw h. _____ alive on _____, 19_____,
and that death occurred, on the date stated above, at _____. m.
The CAUSE OF DEATH* was as follows: Unknown

_____. (duration) _____. yrs. _____. mos. _____. ds.

CONTRIBUTORY
(Secondary)

_____. (duration) _____. yrs. _____. mos. _____. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. Tigart M. D.

Oct. 27 1929 (Address) Goda Spring

Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Oct. 28 1929

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

165-226-003-6491
PLACE OF BIRTH
County of San Joaquin NOV 21 1929
City of Paratello
No. 652 6th St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 28 State File No. 176074

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 9509

FULL NAME OF CHILD

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> (To be answered only in event of plural births)	and { Number in order of birth	Legitimacy <u>Yes</u>	Date of birth <u>Oct 26</u> 19 <u>29</u> (Month) (Day) (Year)
----------------------------	--	--------------------------------------	--------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 10% Argysol

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead 0 Stillborn 0

FATHER	MOTHER
FULL NAME <u>James Ashton Jones</u>	FULL MAIDEN NAME <u>Potts</u>

Residence (Usual place of abode) Paratello

If nonresident, give place and State

Color or race White Age at last Birthday 20

Birthplace Malad, Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at Paratello M.
on the date above stated.

(Signature) P. C. Ray

(Physician or midwife)

Address Paratello, Idaho

Filed 11/1 19 29 J. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

11/11/11

12

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

316-116103-114
PLACED IN NOV 21 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

176091

County of Blaine
City of Paratello
No. 253 Idaho St
General Hospital Registration District No. 28 State File No. 176091
(If born in hospital or institution give name.)
Prim. Registration District No. 2164 Local Registrar's No. 9492
FULL NAME OF CHILD Stillbirth Lawson 3rd mo
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate <u>yes</u>	Date of birth <u>Dec 16</u> 19 <u>29</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9 (a) Born alive and now living 6
Born alive but now dead 0 Stillborn 3

FATHER	MOTHER
FULL NAME <u>James C. Lawson</u>	FULL MAIDEN NAME <u>Mary Stella Jamison</u>
Residence (Usual place of abode) <u>Paratello</u>	Residence (Usual place of abode) <u>Paratello</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>Wht</u> Age at last Birthday <u>49</u>	Color or race <u>Wht</u> Age at last Birthday <u>43</u>
Birthplace <u>Burgonia, Ida</u> (City and State or Country)	Birthplace <u>Burgonia, Ida</u> (City and State or Country)
Occupation <u>Tractor</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:30 P. M. on the date above stated.

(Signature) D. C. Ray

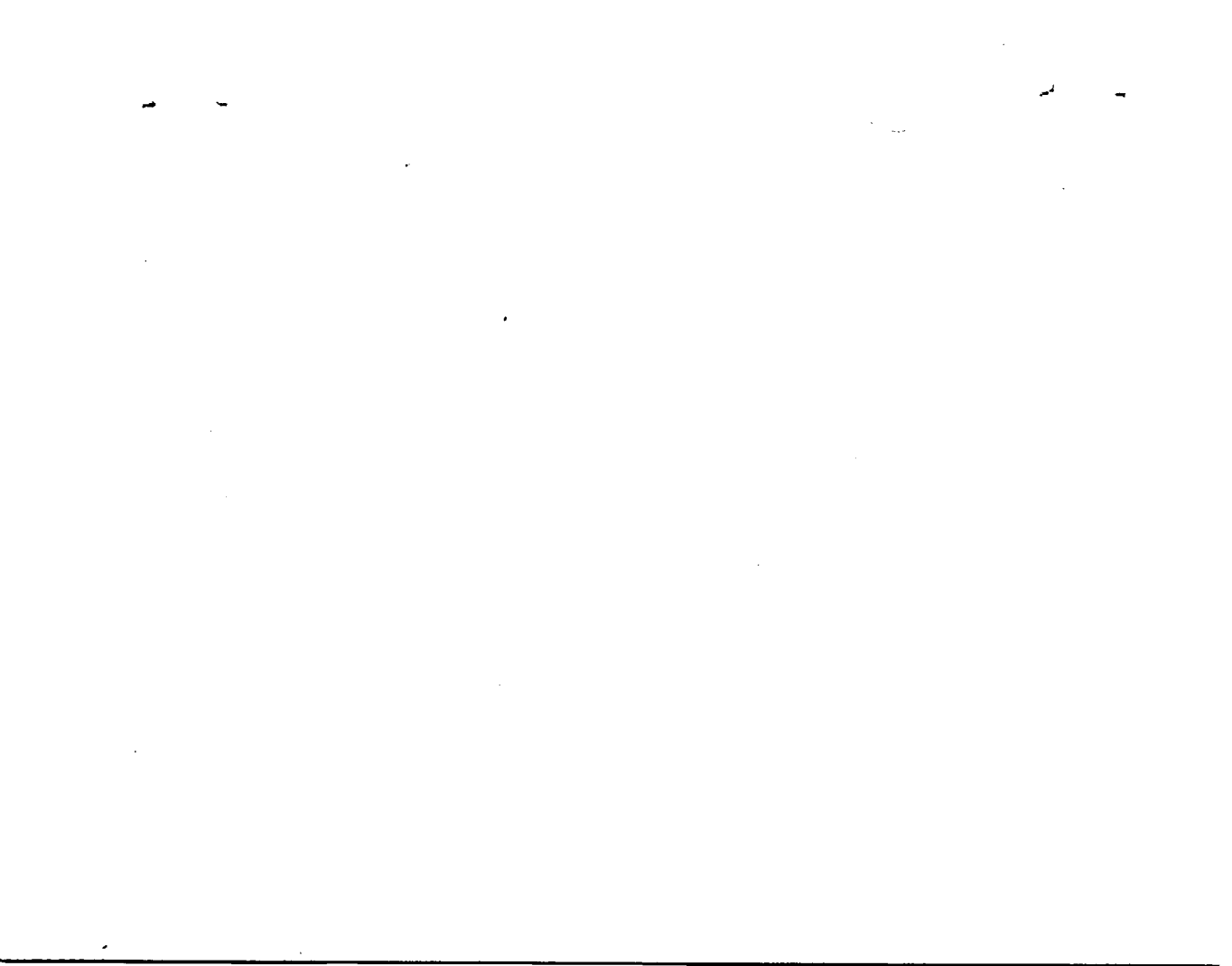
(Physician or midwife)

Address Paratello, Idaho

Filed 11/1 1929 W. J. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 21 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68187

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 214
(No. Pocatello General Hospital)

Local Registrar's No. 5651

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Lawson

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 16, 1929.

7. AGE Years Months Days
0 0 0 Still Born min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER J. C. Lawson

11. BIRTHPLACE OF FATHER (city or town) Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Mary S. Jamison

13. BIRTHPLACE OF MOTHER (city or town) Virginia
(State or Country)

14. Informant J. C. Lawson
(Address) 186 South Idaho St. Poca. Idaho.

15. Filed 11/18, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 16, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 16, 1929, to

that I last saw h. alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Premature birth 2 1/2 mo
Still born.
frequent hemorrhages
in another (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. C. Ray, M. D.
11/18, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Mountain View Cemetery 10/16/29.19

20. Undertaker Arthur V. Hall Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

485-117-003-553

PLACE OF BIRTH

DEC 6 1929

1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lannock
City of Robin
No. _____ St. _____

CERTIFICATE OF BIRTH

176095

Registration District No. 84 State File No. _____

(If born in hospital or institution give name.)

Prim. Registration District No. 2161 Local Registrar's No. 737

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct. 17 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn This one

FATHER
FULL NAME Samuel Joseph Myers

MOTHER
FULL MAIDEN NAME Sharlett Nelson

Residence (Usual place of abode) Robin, Ida

Residence (Usual place of abode) Robin

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 34 (Years)

Color or race White Age at last Birthday 21 (Years)

Birthplace Fairfax, N. C. (City and State or Country)

Birthplace Clarksburg, Ark (City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn ✓ at 145 P M. on the date above stated.

(Signature) B. A. Rich

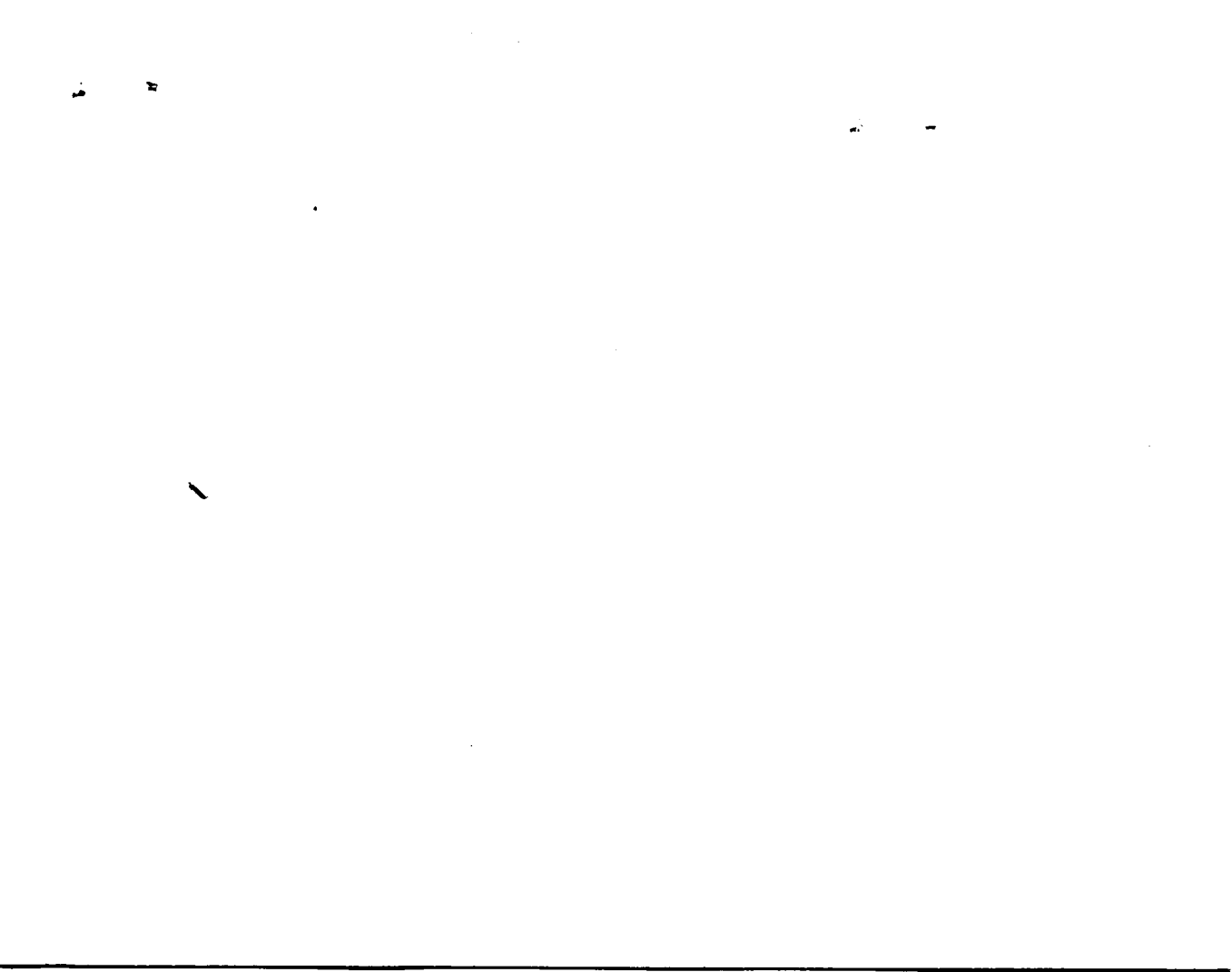
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Lava Hot Springs, Ida

Filed Nov 30 1929 Mrs. G. J. Felt

Registrar



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

PLACE OF DEATH

County of Bannock
City of Robin

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 84
Primary Registration District No. 216

DO NOT WRITE IN THIS SPACE

State File No. 68161

Local Registrar's No. 169

(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stilbuth

(a) Residence. No. 206 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None

6. DATE OF BIRTH (month, day and year) Oct 17, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min. None

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Robin Idaho

10. NAME OF FATHER Samuel Joseph Myers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Gairfax N. C.

12. MAIDEN NAME OF MOTHER Shardette Melson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clarksville Ark.

14. Informant S. J. Myers B. C. Rich
(Address) Robin Ida

15. Filed Nov 30, 1929 Mrs. G. L. Feb
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
on Oct 17, 1929, to 19,
that I last saw him alive on never, 1929,
and that death occurred, on the date stated above, at 1:45 P. m.
The CAUSE OF DEATH* was as follows:

Stilbuth 7 mo. gestation

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Polyhydramnia
(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Ed Rich M. D.

Oct 17, 1929 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial 19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS				State File No. <u>176116</u>	
RECEIVED DEC 13 1929				Registered No. _____	
STANDARD CERTIFICATE OF BIRTH					
1. PLACE OF BIRTH		County <u>Peleeval I de</u>		State <u>Idaho</u> S	
Township <u>Deinet</u>		City _____		or Village _____	
No. _____		St. _____		Ward _____	
2. Full name of child <u>Unamed Parr</u>		If child is not yet named, make supplemental report, as directed			
3. Sex of child <u>4</u>	To be answered ONLY in event of plural births.	4. Twin, triplet or other <u>One</u>	5. Number, in order of birth _____	6. Legitimate? <u>7/10</u>	7. Date of birth <u>Nov 16 - 29</u> (Month, day, year)
8. FATHER Full name <u>Symon Dourpoint</u>			14. MOTHER Full maiden name <u>Leona Parr</u>		
9. Residence (Usual place of abode) <u>Grand Alam Reservoir Idaho</u> If nonresident, give place and State			15. Residence (Usual place of abode) <u>Unatula Reservoir Oregon</u> If nonresident, give place and State		
10. Color or race <u>Indian</u>	11. Age at last birthday <u>23</u> (Years)		16. Color or race <u>Indian</u>	17. Age at last birthday <u>21</u> (Years)	
12. Birthplace (city or place) <u>Grand Alam Reservoir Idaho</u> (State or country)			18. Birthplace (city or place) <u>Unatula Oregon</u> (State or country)		
13. Occupation Nature of Industry <u>Labor</u>			19. Occupation Nature of Industry <u>House wife</u>		
20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)			(a) Born alive and now living _____ (b) Born alive but now dead _____ (c) Stillborn <u>1</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <u>John Parr</u> at _____ m. on the date above stated. (Born alive or stillborn)					
Signature <u>J. A. Nelson</u> (Physician or Midwife)					
Given name added from a supplemental report _____ (Month, day, year)					
Address <u>Des Moines</u>					
Filed <u>Nov 19</u> 19 <u>29</u> <u>John Parr</u> Registrar.					

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 13 1929 STANDARD CERTIFICATE OF DEATH DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS
1 PLACE OF DEATH Zenewah County Idaho State Idaho Registered No. 11
Township Seimet or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Unnamed Parr, illegitimate
(a) Residence. No. _____ St. _____ Ward 206
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX 7 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Nov 16 - 1929

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
Still born

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Oband Glen
(State or country) Idaho

10 NAME OF FATHER Seymour Dornforth

11 BIRTHPLACE OF FATHER (city or town) Oband Glen
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Leona Parr

13 BIRTHPLACE OF MOTHER (city or town) Unatits
(State or country) Idaho

14 Informant Leona Parr
(Address) Seimet, Idaho

15 Filed Nov. 19, 1929 John Parr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Nov 16 19 29

17 I HEREBY CERTIFY, That I attended deceased from at birth, 19 29, to _____, 19 _____, that I last saw him alive on _____, 19 _____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Premature Birth

_____ (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____ If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) J. A. Nelson, M. D.
11/16 19 (Address) Seima

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Seimet, Idaho DATE OF BURIAL Nov. 17 1929

20 UNDERTAKER Joe Sherman ADDRESS Seimet, Idaho

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infantion," "Marasmus," "Old age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

392-225-005-859
PLACE OF BIRTH
County of St. Maries
City of St. Maries
No. _____ St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S176116

Registration District No. 32 State File No. _____

Prim. Registration District No. 2049 Local Registrar's No. 70

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>11 25 1929</u> (Month) (Day) (Year)
-----------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 1.2. Silver nitrate

Number of child of this mother, including present birth 11 (a) Born alive and now living 5

Born alive but now dead 5 Stillborn 1

FATHER
FULL NAME Albert L. Lesjan

Residence (Usual place of abode) St. Maries

If nonresident, give place and State _____

Color or race W Age at last Birthday 42
(Years)

Birthplace Idaho
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Katharine Hengst

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race W Age at last Birthday 39
(Years)

Birthplace Russia
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3209 M.
on the date above stated.

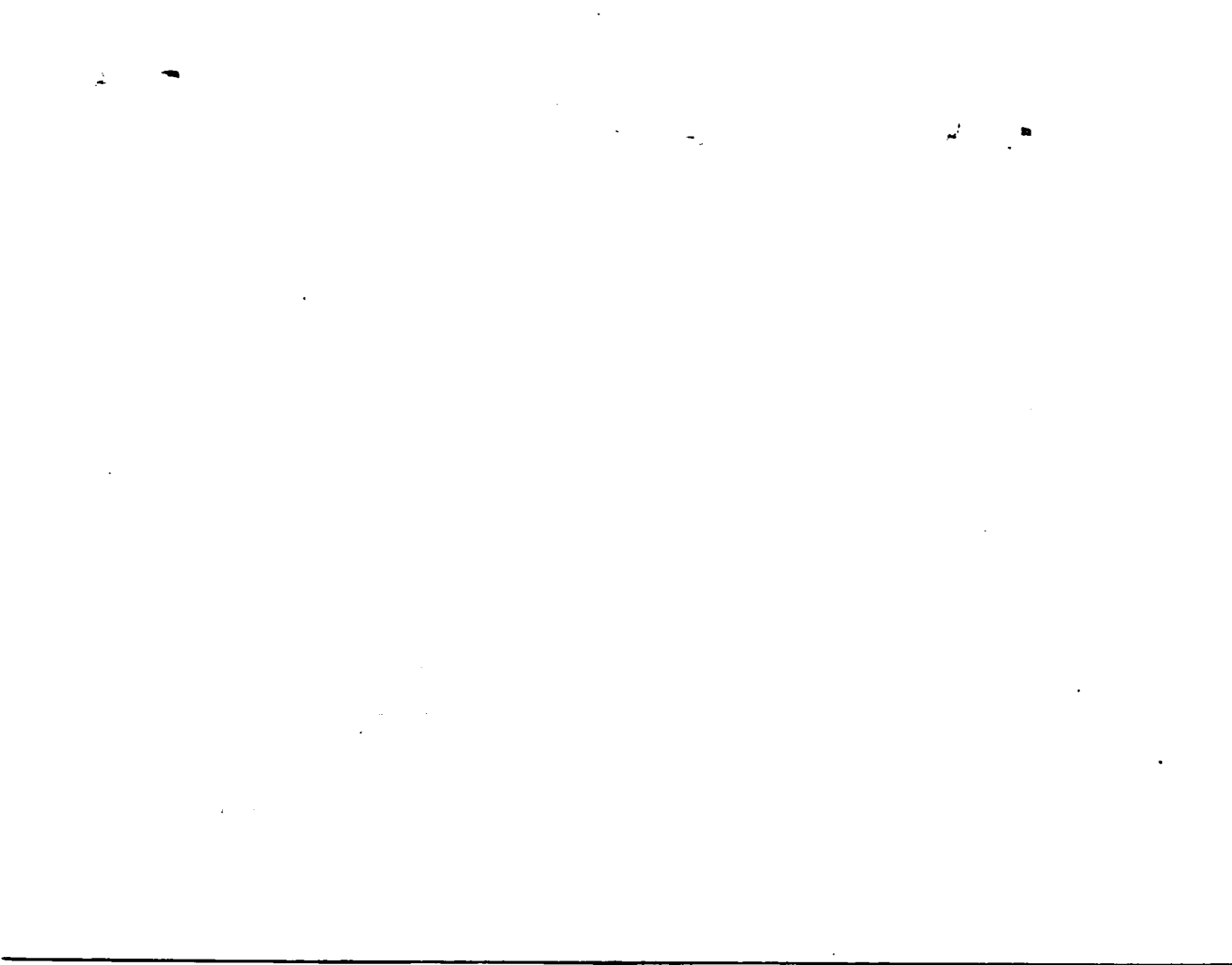
(Signature) [Signature]

(Physician or midwife)

Address St. Maries, Idaho

Filed Dec 7 1929 Walter Boring
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68200

PLACE OF DEATH

County of Benedict
City of St. Maries

Registration District No. 32
Primary Registration District No. 249

Local Registrar's No. 38

(No. 249)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER Albert L. Larson11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway12. MAIDEN NAME OF MOTHER Katherine Bergert13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia14. Informant Mr. John Bergert
(Address) St. Maries, Ida15. Filed Dec 7, 1929 Hubert Bergert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 25 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-25, 1929, to 11-25, 1929
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____m.
The CAUSE OF DEATH* was as follows:

Stillborn

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G. E. Espe M. P.
11-25, 1929 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. Maries, Ida Date of Burial 11-28, 192920. Undertaker None Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

5-108-006-RECEIVED DEC 10 1929

PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. E. Judicial St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 176136

Registration District No. 121 State File No. 375

Prim. Registration District No. 1007 Local Registrar's No. 375

(If born in hospital or institution give name.)

FULL NAME OF CHILD Stillborn Queen

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Nov 9 1929</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 3 (a) Born alive and now living

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Lahen J. Queen

Residence (Usual place of abode) Blackfoot

If nonresident, give place and State

Color or race White Age at last Birthday 48 (Years)

Birthplace Illinois

(City and State or Country)

Occupation Laborer

MOTHER
FULL MAIDEN NAME Bernice Murphy

Residence (Usual place of abode) Blackfoot

If nonresident, give place and State

Color or race White Age at last Birthday 36 (Years)

Birthplace Kansas

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 A M. on the date above stated.

(Signature) W. Beck

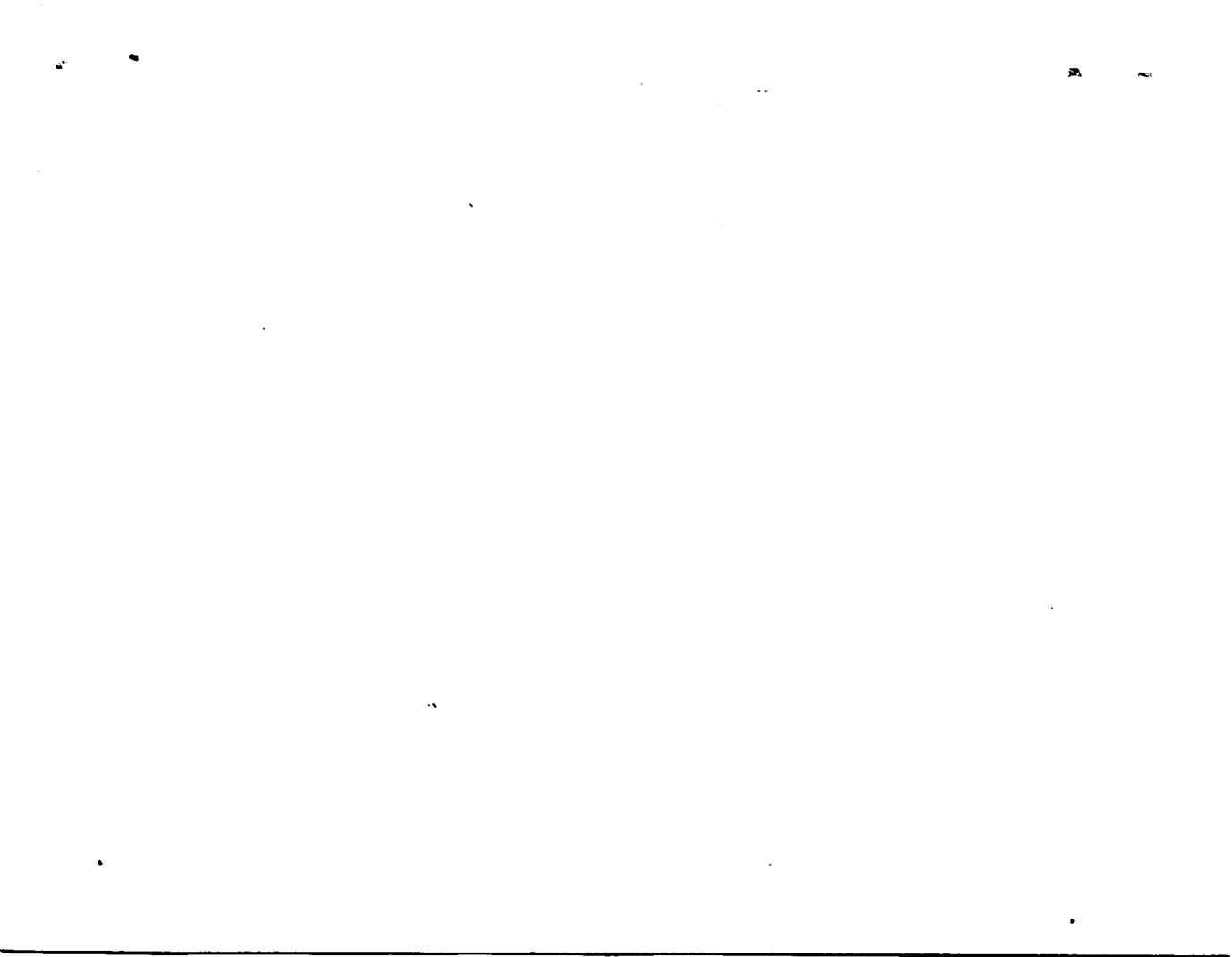
(Physician or midwife)

Address Blackfoot, Ida

Filed Dec 6 1929 M. L. L. & L. L.

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68299

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. 276 E. Judicial)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 191

2. FULL NAME Stillborn Queen

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Nov 9, 1929

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Blackfoot, Ida
(State or country)

10. NAME OF FATHER Laben J. Queen

11. BIRTHPLACE OF FATHER (city or town) Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Bernice Murphy

13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Laben J. Queen
(Address) Blackfoot 276 E. Judicial

15. Filed Nov. 10, 1929 by Mr. Walter E. Tabie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 9, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 9, 1929 to Nov 9, 1929
that I last saw him alive Stillborn, 1929

and that death occurred, on the date stated above, at 1:00 a. m.

The CAUSE OF DEATH* was as follows:

Premature 6 1/2 mo
Cause I could not determine
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. W. Beck, M. D.

Nov 9, 1929 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Entombment

Y.C. Cem. Blackfoot Date of Burial Oct 2, 1929

20. Undertaker

L. J. Queen Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PL. REC'D / I.D. DEC 11 1929

County of Blaine
City of Bellevue

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 176174

No. St.

73-221-007264

Registration District No. 57 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2022 Local Registrar's No. 74

FULL NAME OF CHILD

Alta May Lilya
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 21</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Lawrence Lilya
Residence (Usual place of abode) Dannett, Ida

MOTHER
FULL MAIDEN NAME May Douthett
Residence (Usual place of abode) Dannett, Ida

If nonresident, give place and State
Color or race White Age at last Birthday 30
Birthplace Dannett, Ida (Years)
(City and State or Country)
Occupation Farmer

If nonresident, give place and State
Color or race White Age at last Birthday 26
Birthplace Dannett, Ida (Years)
(City and State or Country)
Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 130 P. M.
on the date above stated.

(Signature) E. W. Fox

(Physician or midwife)

Address 14 S. Main, Ida

Filed 12-19 1929 Robert H. Wright
Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1911

1911

RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68227

PLACE OF DEATH

County of Blaine
City of Garnett

Registration District No. 57
Primary Registration District No. 2022

Local Registrar's No. 43

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Lydia(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

1. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>Nov 21 - 1929</u>		
7. AGE <u>Born dead</u>	Years <u> </u>	Months <u> </u>
Days <u> </u>		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>X</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>		
(c) Name of employer <u>X</u>		

9. BIRTHPLACE (city or town) Garnett, Ida.
(State or country)10. NAME OF FATHER Lawrence Lydia11. BIRTHPLACE OF FATHER (city or town) Garnett, Ida.
(State or Country)12. MAIDEN NAME OF MOTHER Bessie Porter13. BIRTHPLACE OF MOTHER (city or town) Salt Lake City
(State or Country)14. Informant La. Lydia
(Address) Garnett, Ida.15. Filed 12-10, 19 29 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 21 19 29
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
11/21, 19 29, to 11/21, 19 29
that I last saw her alive on November 21, 19 29
and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
Trisomy 21
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) R. H. Wright, M. D.11/21, 19 29 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Springer Cemetery Date of Burial Nov 22 192920. Undertaker Harist & Co. Address Hailey, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

176174 N

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JAN 7 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho JAN 2 1930
176174

Mrs. L. Lilya
Gannett

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Alta Mary Lilya

PLACE OF BIRTH** Bellevue DATE OF BIRTH Nov. 21 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 5
2. Number born alive and now living 3
3. Born alive but now dead _____
4. Number of children stillborn 2

(Please write plainly)

Information with reference to
FATHER

Laurence A. Lilya
(Full name)
Gannett Idaho
(Residence)
Age at last birthday 33 yrs.
Gannett Idaho
(Birthplace)
Farmer
(Occupation)

Information with reference to
MOTHER

Mary R. Southern
(Full Maiden name)
Gannett Idaho
(Residence)
Age at last birthday 24
Salt Lake City Utah
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

439-129-009-895
PLACE OF BIRTH
RECEIVED DEC 6 1929

County of Bonner
City of Sandpoint
No. 502 Alder St.
Sandpoint Hospital
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 176196

Registration District No. 78 State File No. 176196
Prim. Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD Edward K. McInaney (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>10-29-29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Donald Joseph McInaney
Residence (Usual place of abode) Sandpoint
If nonresident, give place and State
Color or race white Age at last Birthday 33 (Years)
Birthplace Pelican Rapids, Minn.
(City and State or Country)
Occupation Auto Salesman

MOTHER
FULL MAIDEN NAME Nora Hines
Residence (Usual place of abode) Sandpoint
If nonresident, give place and State
Color or race White Age at last Birthday 34 (Years)
Birthplace Phillipsburg, Mont.
(City and State or Country)
Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

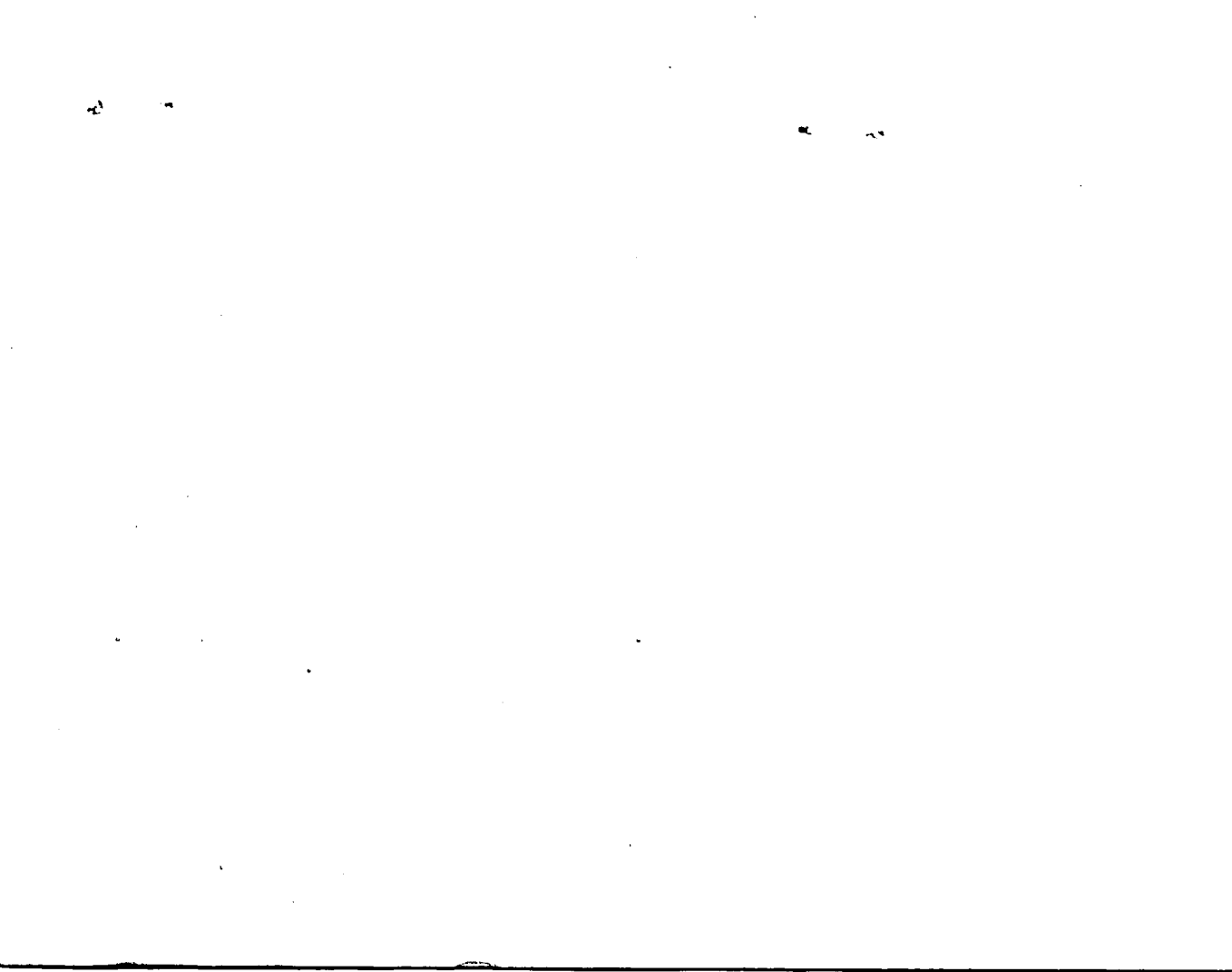
I hereby certify that I attended the birth of this child, who was Stillborn at 1:15 P M.
on the date above stated.

(Signature) C. P. Staehle
Physician
(Physician or midwife)

Address Sandpoint, Idaho.

Filed Dec 3 1929 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1929

PLACE OF DEATH

County of BonnerCity of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155(No. Sandpoint Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 67896

Local Registrar's No. _____

2. FULL NAME Edward H. McInaney (Stillborn)(a) Residence. No. 506 Boyer St.

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male4. COLOR OR RACE white5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Oct 29 19297. AGE Years Months Days If LESS than 1 day, hrs. or min.
1 11 18 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho10. NAME OF FATHER Don J. McInaney11. BIRTHPLACE OF FATHER (city or town) Munn
(State or Country)12. MAIDEN NAME OF MOTHER Mora Hines13. BIRTHPLACE OF MOTHER (city or town) Mont
(State or Country)14. Informant DJ McInaney
(Address) Sandpoint15. Filed Oct. 30, 1929 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)29
(Day)1929
(Year)17. I HEREBY CERTIFY, That I attended deceased from at
birth 10/29, 1929, to 19that I last saw him alive on, 1929

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Death in uterus - slow
drainage liquor amnii
over 6 days - breech presentation
Premature 5-6 mo (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) C. P. Staccatura, M. D.10-30-, 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Lakewood Cemetery Oct 30 1929

20. Undertaker

Address

Turnbull Co Sandpoint

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

237-111009-255
PLACE RECORD DEC 6 1929

County of Bonner
City of Sandpoint
No. 502 Alder St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 176197

Sandpoint, Hospital Registration District No. 76 State File No. 176197
(If born in hospital or institution give name.)
Prim. Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth.
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Nov. 11</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 0 (a) Born alive and now living _____
Born alive but now dead _____ Stillborn 2

FATHER	MOTHER
FULL NAME <u>Arthur Henry St. Germain</u>	FULL MAIDEN NAME <u>Genieve Veronica Kenny</u>
Residence (Usual place of abode) <u>Clarksfork, Ida.</u>	Residence (Usual place of abode) <u>Clarksfork, Ida.</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)
Birthplace <u>Wallace</u> (City and State or Country)	Birthplace <u>Sturgeon Bay, Wis.</u> (City and State or Country)
Occupation <u>Miner, Rancher.</u>	Occupation <u>Wife.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

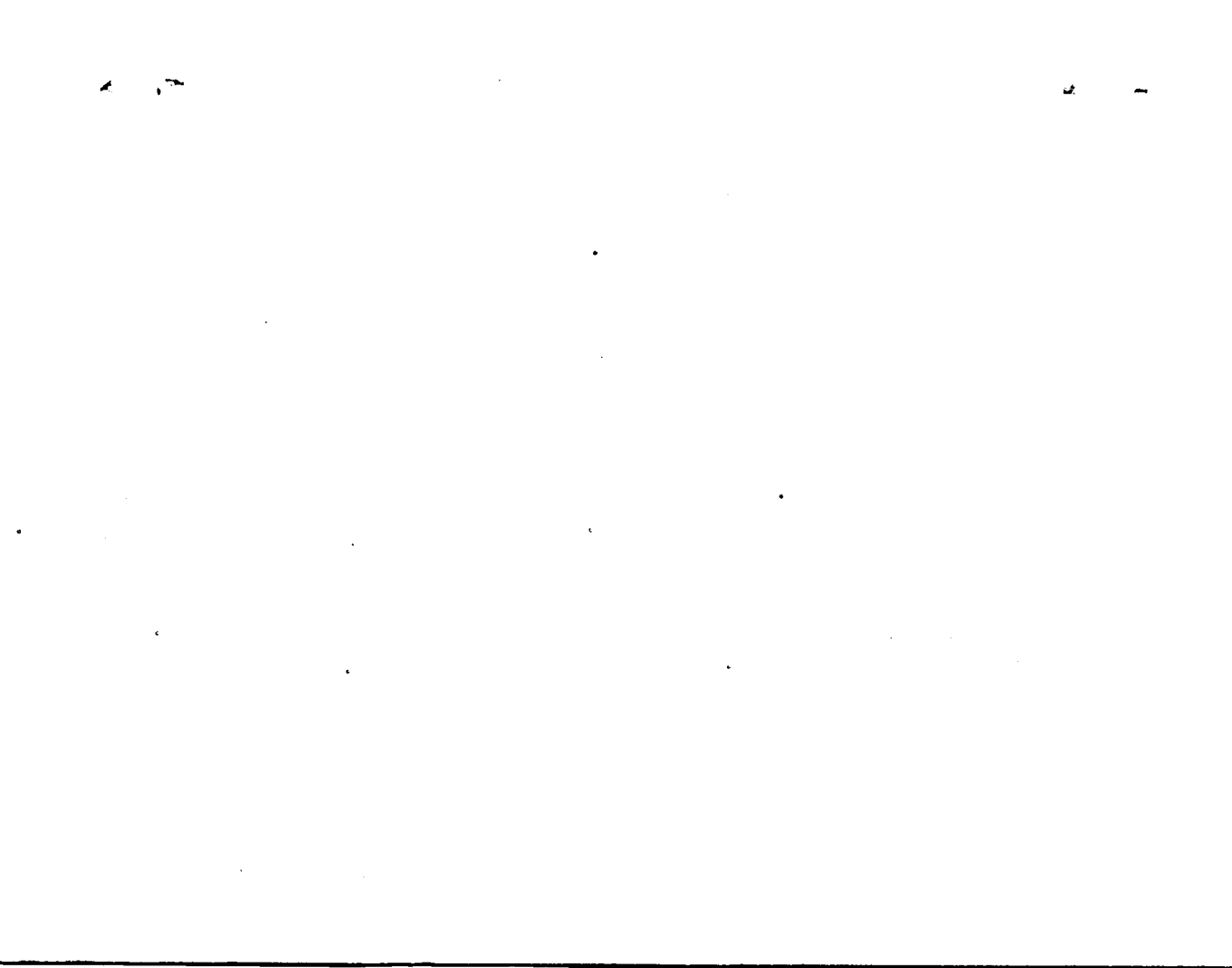
I hereby certify that I attended the birth of this child, who was Stillborn at 3:10 P M.
on the date above stated.

(Signature) E. P. Haachouse
Physician
(Physician or midwife)

Address Sandpoint, Idaho.

Filed Dec 3 1929 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECORDED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68225

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Sandpoint Hospital St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 19, 1929

7. AGE Stillborn Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER Arthur St Germain

11. BIRTHPLACE OF FATHER (city or town) Sawyer
(State or Country) Wis.

12. MAIDEN NAME OF MOTHER Genevieve Penny

13. BIRTHPLACE OF MOTHER (city or town) Osborne
(State or Country) Idaho

14. Informant Arthur St Germain
(Address) Clarksfork Idaho

15. Filed Nov 23, 1929

Viola Allers
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 19 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth Nov 19, 1929
that I last saw him alive on Nov 19, 1929

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Death in utero. Cord
three times around neck
tight. Last felt life 13th Nov.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C. P. Stachowicz M. D.

11-25- 1929 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Prescott Cemetery Nov 23, 1929

20. Undertaker

Address

Moore Mortuary Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

295-112-018-766
PLACE OF BIRTH
County of Banyon
City of Baldwell
DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

Registration District No. 3 State File No. 176244

(If born in hospital or institution
give name.)

Prim. Registration District No. 1005 Local Registrar's No. 212

FULL NAME OF CHILD

Stillbirth King
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate?

Date of
birth

Nov 12
(Month) (Day)

1929
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1

(a) Born alive and now living 1

Born alive but now dead 0

Stillborn 1

FATHER

FULL
NAME

Earl Lawson King

Residence (Usual place of abode)

Baldwell

If nonresident, give place and State

Color or race

white

Age at last Birthday

32
(Years)

Birthplace

Paonia, Colorado
(City and State or Country)

Occupation

Laborer

MOTHER

FULL
MAIDEN
NAME

Stella Louise Lowrey

Residence (Usual place of abode)

Baldwell

If nonresident, give place and State

Color or race

white

Age at last Birthday

19
(Years)

Birthplace

Pleasant Plains, Iowa
(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

Stillborn { Born alive } at 3:45 Nov 12 P. M.
(Signature) C. R. Whittenburger
osteopath
(Physician or midwife)

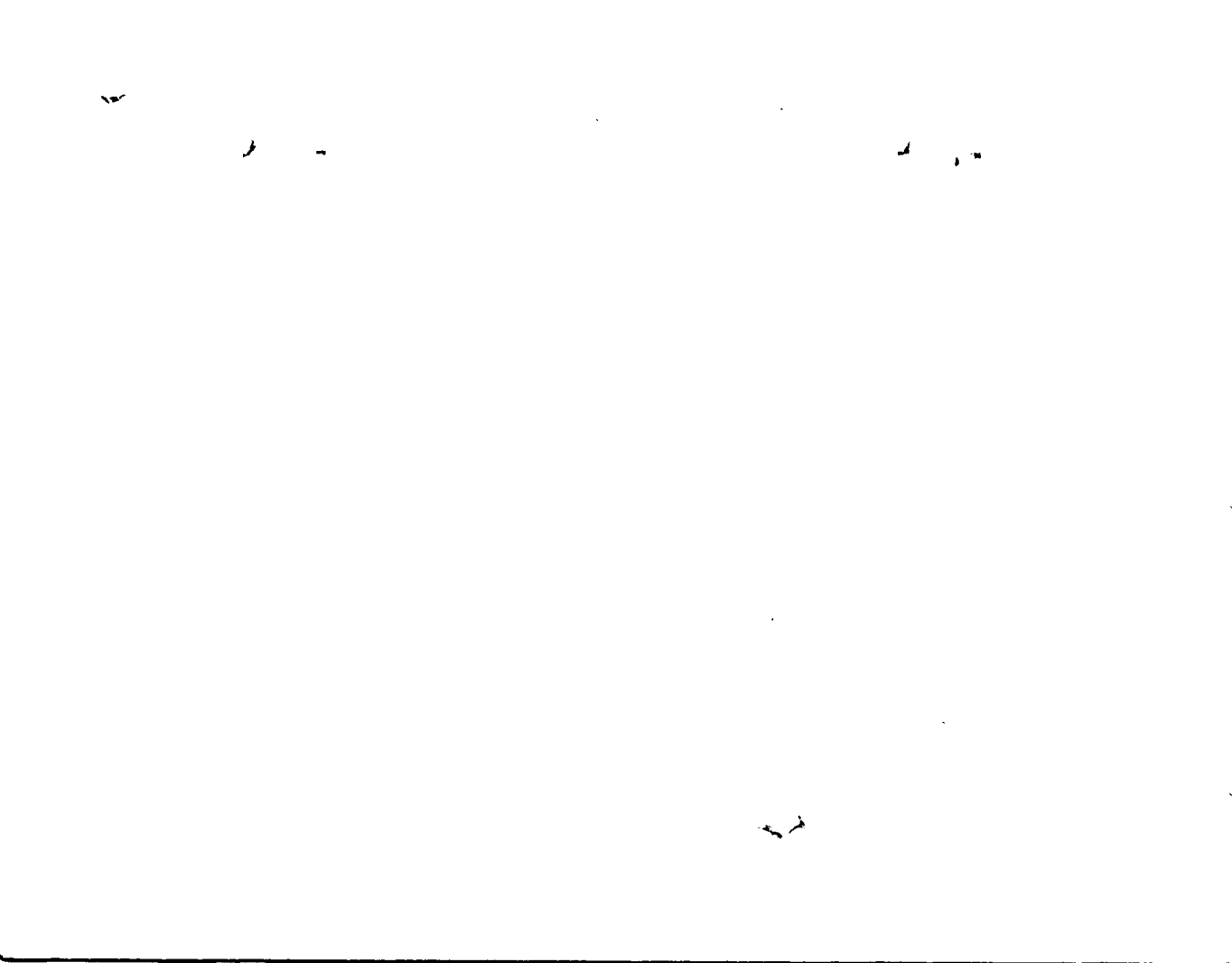
Address

Baldwell, Idaho

Filed

11-23-1929 John S. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED DEC 11 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68776

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 126

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby King

(a) Residence No. 7th & 4th St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 12 - 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborne

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell, Idaho
(State or country)

10. NAME OF FATHER Earl L. King

11. BIRTHPLACE OF FATHER (city or town) Paonia Colo.
(State or Country)

12. MAIDEN NAME OF MOTHER Stella Louise Govey

13. BIRTHPLACE OF MOTHER (city or town) Pleasant Plains Iowa
(State or Country)14. Informant Carl L. King
(Address) Caldwell, Idaho, Res. 415. Filed 11-25-1929 John S. Meyers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov 12, 1929

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

In utero - Mrs. King was in car wreck three weeks previous to birth. No doubt death to baby was caused by traumatism during the car wreck and it was a breech presentation which made head of car baby get the bump.

18. Where was disease contracted? Not a place of death.

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Child was necrotic

(Signed) C. R. Whittemberger, M.D.

Nov. 25, 1929. (Address) Caldwell, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Private Date of Burial 11-13-1929

20. Undertaker Father & Friends Address Caldwell, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of _____ RECEIVED DEC 2 1929

City of _____

No. _____ St. _____

256-104-016254

(If born in hospital or institution give name.)

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Oct 4</u> 19 <u>29</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate 2%

Number of child of this mother, including present birth seven Born alive and now living five

Born alive but now dead _____ Stillborn one

FATHER FULL NAME <u>Roland B. Snow</u>	MOTHER FULL MAIDEN NAME <u>Luella Anderson</u>
---	---

Residence (Usual place of abode) Burley

If non-resident, give place and State _____

Color or race white Age at last Birthday 42 (Years)

Birthplace Utah (City and State or County)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn _____ at 8:00 A.M. on the date above stated.

(Signature) Hugh E. Dean

(Physician or midwife)

Address Burley, Id.

Filed 11-26 1929 F. K. Curtis Registrar.

S

176294

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168-104-018-493
PLAQUE OF BIRTH
RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 176311

County of Clearwater -

City of Ahsahka

No. St. Registration District No. 20 State File No.

Hospital Primary Registration District No. 2187 Local Registrar's No. 81

FULL NAME OF CHILD Unnamed Baby Joy
(Certificate of no value without full name of child)

Sex of Child Male	Twin Triplet or other?	and { Number in order of birth	Legitimate? yes	Date of birth Nov, 4th 1929
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth		Number of child of this mother now living, including present birth	
FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
Scott Joy		Edna Miller	
RESIDENCE		RESIDENCE	
Ahsahka, Idaho		Ahsahka, Idaho	
COLOR	AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY
White	39 (Years)	White	24 (Years)
BIRTHPLACE		BIRTHPLACE	
Idaho		Idaho	
OCCUPATION		OCCUPATION	
Laborer		Housewife	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 4:30 A.M. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192...

(Signature) P. J. Hopkins

(Physician or midwife)

Address Orofino, Idaho

Filed 11/15 1929

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 9 1929

STATE OF IDAHO

County of Fremont

DEPARTMENT OF PUBLIC WELFARE

City of New Dale

BUREAU OF VITAL STATISTICS

No. 154-224-022-816 St.

CERTIFICATE OF BIRTH

(If born in hospital or institution
give name.)

Registration District No. 100 State File No. 176363

Prim. Registration District No. 2178 Local Registrar's No. 296

FULL NAME OF CHILD

Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>✓</u>	and	Number in order of birth <u>✓</u>	Legiti- mate? <u>yes</u>	Date of birth <u>10 24 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? Still - birth

Number of child of this mother, including present birth 87 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 3

FATHER FULL NAME <u>Harry Anderson</u>	MOTHER FULL MAIDEN NAME <u>Florence Hawley</u>
---	---

Residence (Usual place of abode) <u>New Dale</u>	Residence (Usual place of abode) <u>New Dale</u>
--	--

If nonresident, give place and State

Color or race <u>White</u> Age at last Birthday <u>35</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>37</u> (Years)
---	---

Birthplace <u>England, Devon, Eng.</u> (City and State or Country)	Birthplace <u>England</u> (City and State or Country)
--	---

Occupation <u>Farming</u>	Occupation <u>House - wife</u>
---------------------------	--------------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Delivered at 10:30 P. M.
on the date above stated.

(Signature) Edith M. Sutcliffe

(Physician or midwife)

Address Pexburg Idaho

Filed 14 19 29 Myron

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

W
D

RECEIVED JAN 21 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho JAN 6 1930

176363

Mrs. H. Anderson
Newdale

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD None - was stillborn, breech birth
instrument case

PLACE OF BIRTH** Newdale DATE OF BIRTH Oct. 24 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 7
2. Number born alive and now living 4
3. Born alive but now dead
4. Number of children stillborn 3

(Please write plainly)

Information with reference to
FATHER

Harry Anderson
(Full name)

Idaho Falls (Idaho)
(Residence)

Age at last birthday 35

Colorado
(Birthplace)

Ranch hand
(Occupation)

Information with reference to
MOTHER

7 Lorence Hawley
(Full Maiden name)

(Residence)

Age at last birthday 37

England
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C. K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

312-1071-032-458
RECEIVED DEC 4 1929

County of Shoshone
City of Shoshone
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

176500

Registration District No. 16 State File No.
Prim. Registration District No. 1016 Local Registrar's No. 24

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number of birth of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 7</u> (Month) (Day) (Year) <u>1929</u>
--------------------------	---	--------------------------------------	--------------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Melvin Gus Cassell</u>	MOTHER FULL MAIDEN NAME <u>Edna Mayors</u>
---	---

Residence (Usual place of abode) Shoshone

If nonresident, give place and State

Color or race white Age at last Birthday 26 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 10 7, M.
on the date above stated.

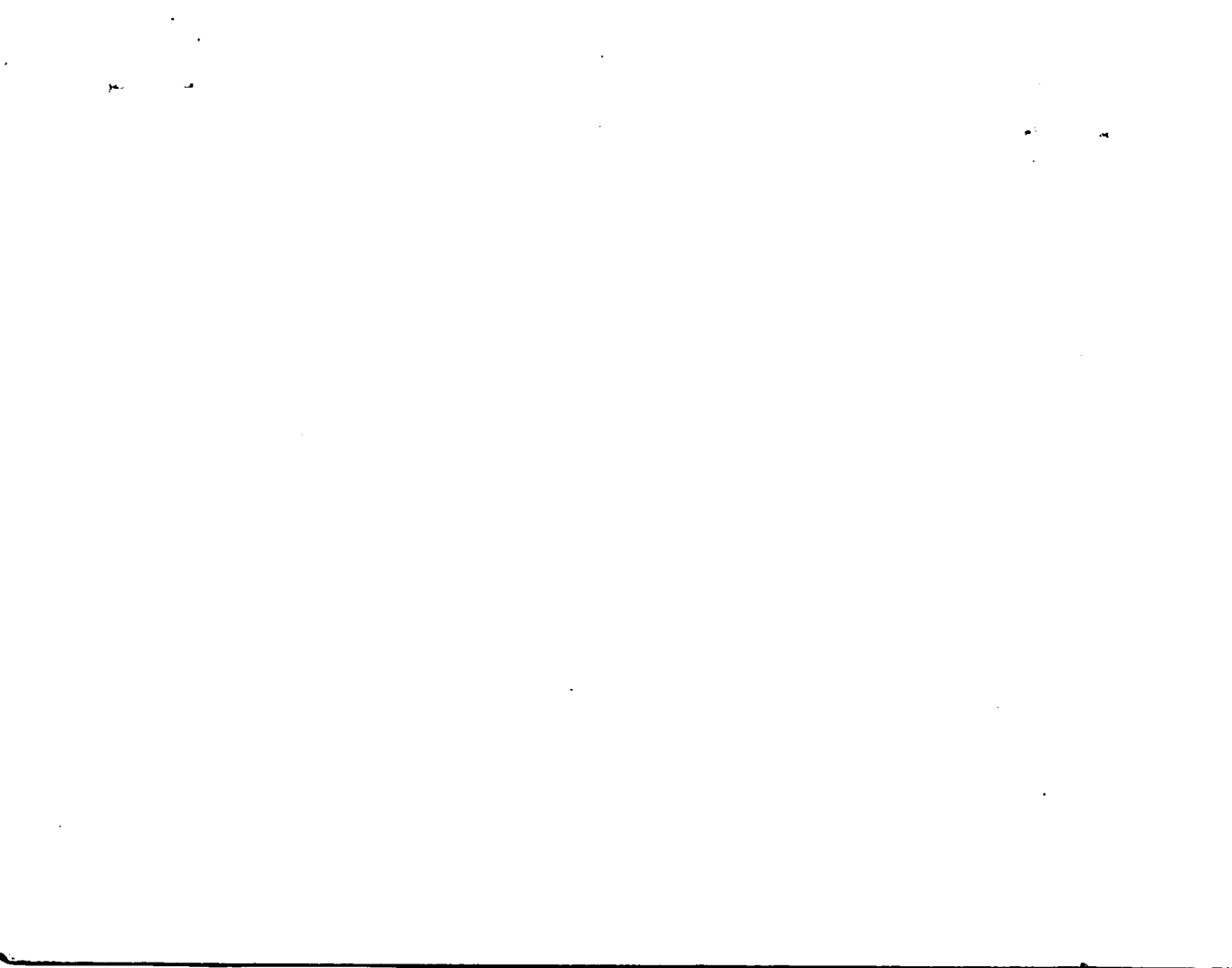
(Signature) F. E. Barrett M.D.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address

Filed Aug 16 1929 J. L. Green Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 4 1929

PLACE OF DEATH

County of LincolnCity of ShoshoneSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 18Primary Registration District No. 216

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stanley Gordon Cassell(a) Residence. No. Shoshone Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred yes mos. ds. How long in U. S., if of foreign birth? yes yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

July 8 19 29

Registrar

DO NOT WRITE IN THIS SPACE

State File No. 68445Local Registrar's No. 12

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July
(Month)7
(Day)19 29
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. E. J. J. J., M. D.July 8 19 29 (Address) Shoshone Ida*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

SSY-122-036-296
PLAQUE DE BIRTH, DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S - 2

County of Conida
City of Malad

CERTIFICATE OF BIRTH

176562

No. _____ St. Registration District No. 26 State File No. _____
Hospital Mrs. Humbert Primary Registration District No. 2069 Local Registrar's No. 134

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	} and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>11-22</u> 192 <u>9</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? no.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth none

FATHER
FULL NAME Carl Neuman
RESIDENCE Malad Ida
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Kansas
OCCUPATION laborer

MOTHER
FULL MAIDEN NAME Velma Brown
RESIDENCE Malad Ida
COLOR white AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Okla
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Positive } at 11 P M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

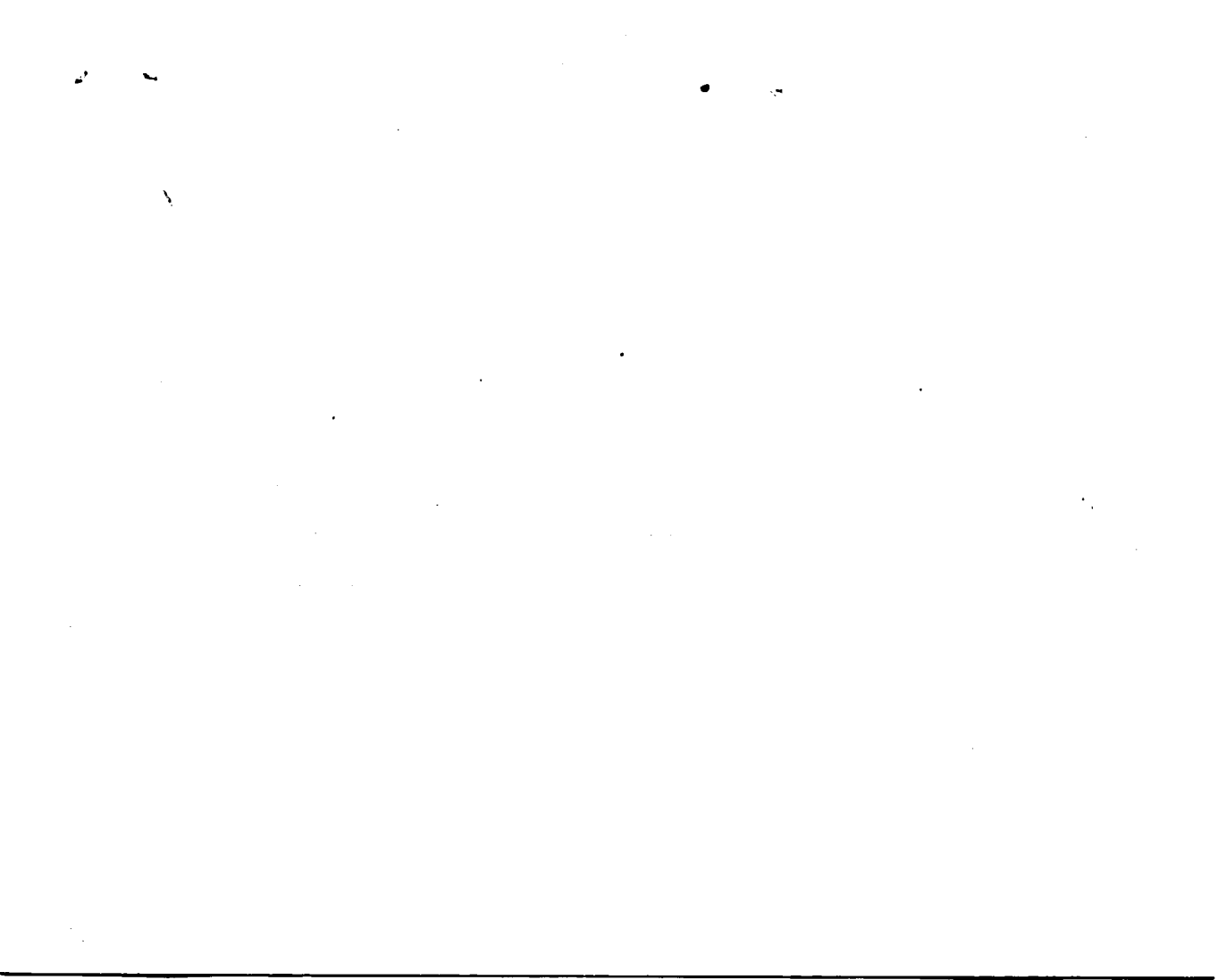
(Physician or midwife)

Address

Filed

Registrar.

Registrar.



RECORDED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68424

PLACE OF DEATH
County of Camden
City of MolokaiRegistration District No. 2069
Primary Registration District No. 2069Local Registrar's No. 36(No. 2069)
(If death occurred in a hospital or institution, give its name, street and number.)

2. FULL NAME

(a) Residence. No. Boley Newman (Stillborn) St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Stillborn</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years <u>—</u>	Months <u>—</u>	Days <u>—</u>
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) (State or country)	<u>Molokai Ida</u>
10. NAME OF FATHER	<u>Carl Newman</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country)	<u>Kansas</u>
12. MAIDEN NAME OF MOTHER	<u>Nelma Brown</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)	<u>Idaho</u>

14. Informant (Address)	<u>J. M. Kimes</u> <u>Superintendent</u>
15. Filled <u>11-22</u> , 19 <u>29</u>	<u>J. M. Kimes</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 22, 19 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him was still born, 19 29and that death occurred, on the date stated above, at — m.The CAUSE OF DEATH* was as follows:
Stillborn. Had been dead about 5 or 6 days when born.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Kimes D.11-22, 19 29 (Address) Molokai Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Molokai Ida</u>	Date of Burial <u>Nov. 23</u> , 19 <u>29</u>
20. Undertaker <u>J. Gray Benson</u>	Address <u>Molokai Ida</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

515-210-036-231
PLACE OF BIRTH

RECEIVED DEC 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida

City of Malad

CERTIFICATE OF BIRTH 26 176567

No. St. Registration District No. State File No.

Hospital Community Primary Registration District No. 2069 Local Registrar's No. 129

FULL NAME OF CHILD (Stillbirth)

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Nov. 10, 1929</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Mr Henry Vanderwood</u>		<u>J. Bernelia Starr</u>	
RESIDENCE <u>Malad, Idaho Route 1</u>		RESIDENCE <u>Malad, Idaho Route 1</u>	
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)		COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>38</u> (Years)	
BIRTHPLACE <u>Malad, Idaho</u>		BIRTHPLACE <u>Starr Ranch, Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 19 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) [Signature]

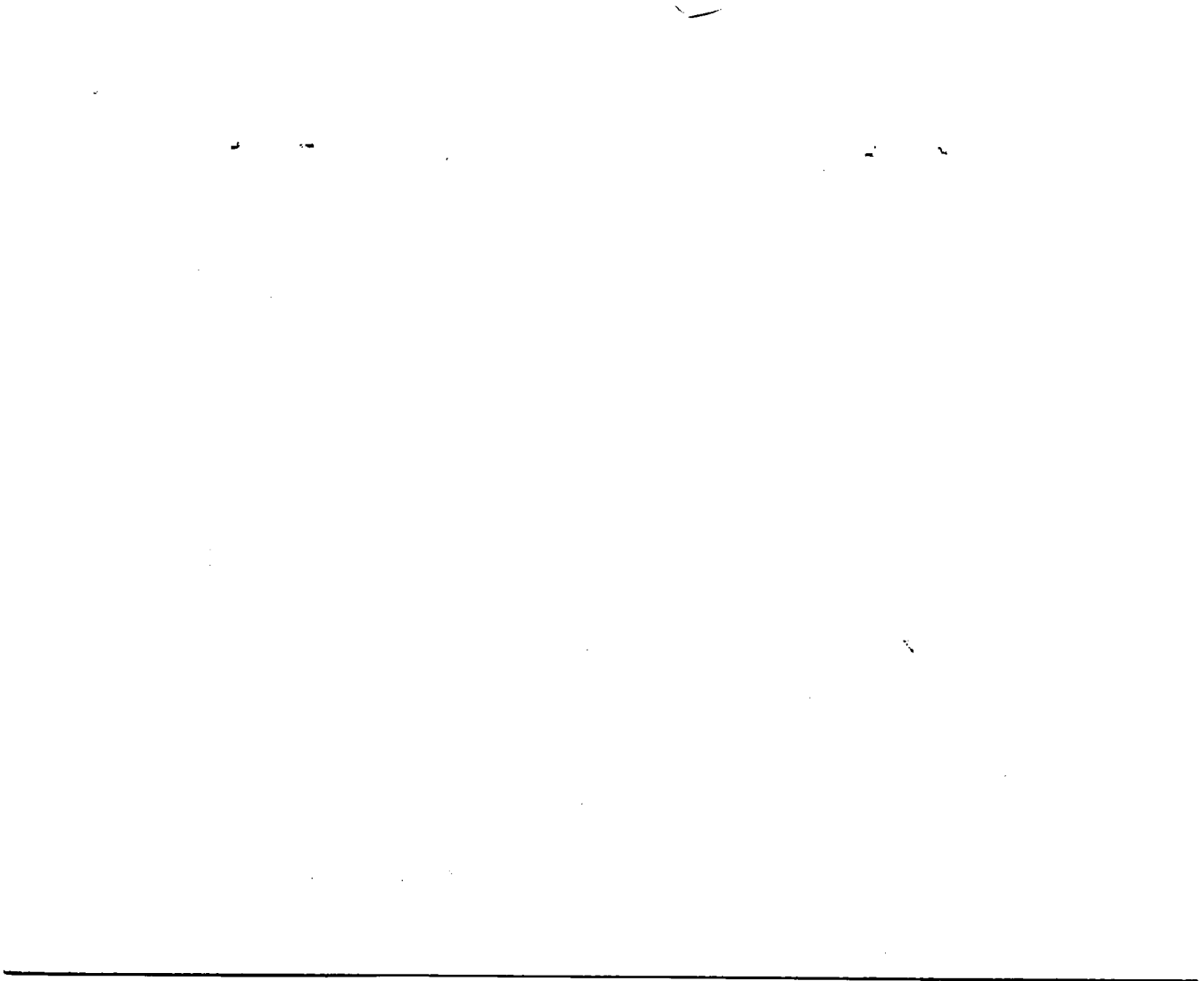
(Physician or midwife)

Address Malad, Idaho

Filed 11-30 1929 J. M. Arndt

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William H. Vandermore

CERTIFICATE OF DEATH

Registration District No. 26Primary Registration District No. 2069

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 65126Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov-11 1929
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Malad, Idaho

10. NAME OF FATHER

William H. Vandermore

11. BIRTHPLACE OF FATHER

(State or Country)

Malad, Idaho

12. MAIDEN NAME OF MOTHER

June Ottar

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William H. Vandermore

(Address)

Malad, Idaho R.F.D. #1

15.

Filed 11-30 1929

Local Registrar

J. M. Kerns

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov-11 1929
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
1929, to Nov-11 1929that I last saw him alive on Nov-11 1929
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Still Born
cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Vandermore M.D.11/13/1929 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Church Nov-12-29

20. UNDERTAKER

ADDRESS

J. L. Leman Malad, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 2 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Payette
City of Payette
No. 234-188-038-263 St. 3

CERTIFICATE OF BIRTH

176571

Registration District No. 51 State File No. 176571

(If born in hospital or institution
give name.)

Prim. Registration District No. 2130 Local Registrar's No. 17

FULL NAME OF CHILD

Stillbirth (Macerated)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>m</u>	Twin Triplet or other? <u> }</u> and <u> }</u> (To be answered only in event of plural births)	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>10/18</u> 19 <u>25</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 5

Born alive but now dead none Stillborn 2

FULL NAME <u>A. F. Shuman</u> FATHER	FULL MAIDEN NAME <u>Mae Buttrick</u> MOTHER
---	--

Residence (Usual place of abode) Payette Idaho

If non-resident, give place and State

Color or race w Age at last Birthday 62 (Years)

Birthplace Wisconsin (City and State or Country)

Occupation Labourer

Color or race w Age at last Birthday 38 (Years)

Birthplace Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7 P. M.
on the date above stated.

(Signature) Roderic Belknap

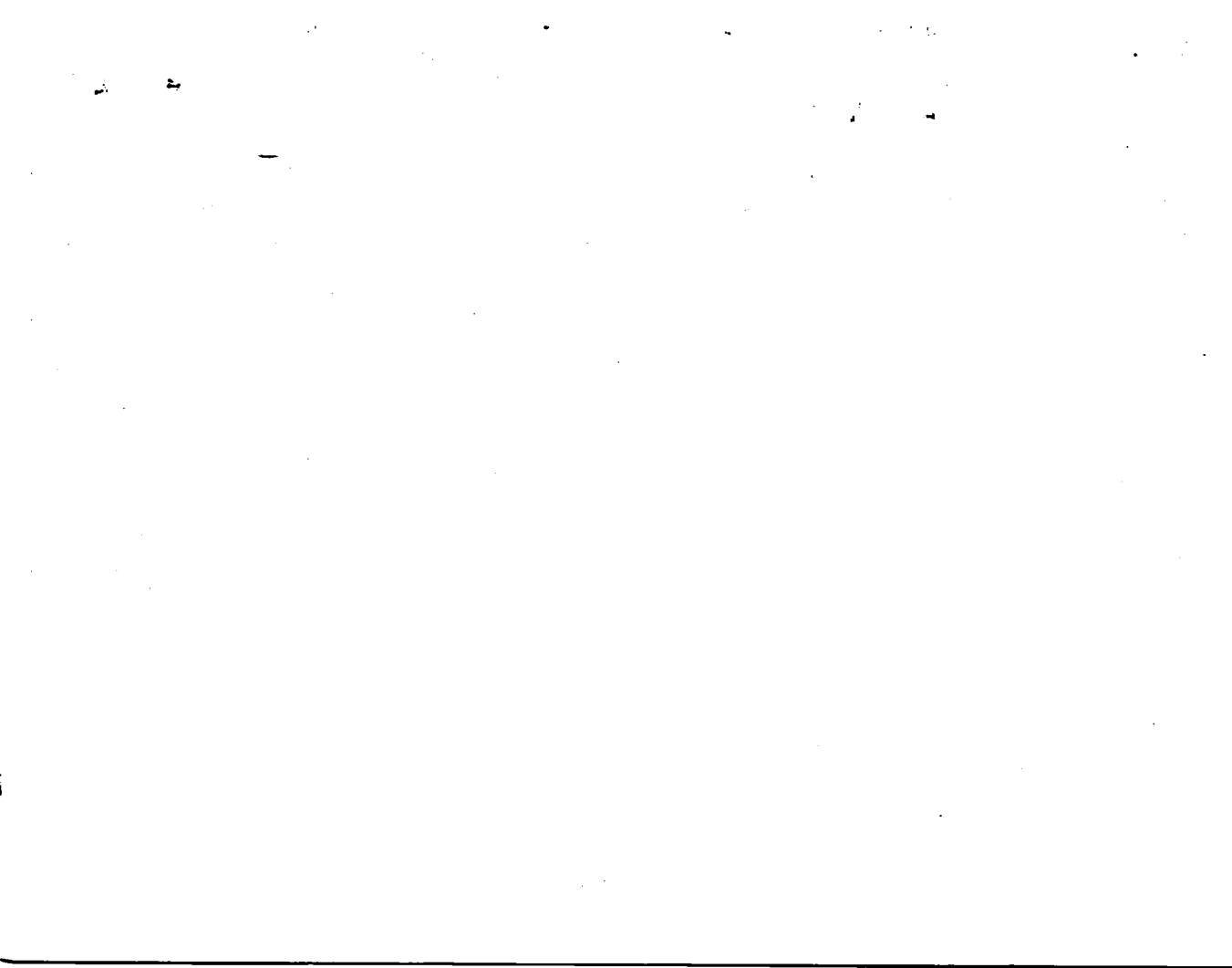
(Physician or midwife)

Address Cutler Ave

Filed Oct 25 1929 Mrs W. J. Drysdale

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69995

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008

Local Registrar's No. 36

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth B. Blume
(a) Residence. No. Payette, Ida. St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Baby
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) _____
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
none — — _____
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Payette (State or country) _____
10. NAME OF FATHER A. F. Blume
11. BIRTHPLACE OF FATHER (city or town) Wis (State or Country) _____
12. MAIDEN NAME OF MOTHER Mrs. B. H. Hoff
13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country) _____

14. Informant A. F. Blume (Address) Payette, Ida.

15. Filed Oct 18, 1929 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Not Known 19____
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3 Pm 10/18, 1929, to 7 30 Pm 10/18, 1929
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Stillbirth
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Not Known (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) Roderic B. Blume M. D.
10/22, 1929 (Address) Centerville, Ore.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette, Ida. Date of Burial Oct 19 1929
20. Undertaker Glenn C. Sanden Address Payette, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

266-121-545-238
PLACE OF BIRTH
RECEIVED DEC 11 1929
County of Lum. Falls
City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

176634

No. St.

T. F. Co. 4 gen.
(If born in hospital or institution
give name.)

Registration District No. 37 State File No.

Prim. Registration District No. 2085 Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct. 21</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	--	-------	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Heber Neal Boncourt</u>	FULL MAIDEN NAME <u>Margaret Scherb</u>

Residence (Usual place of abode) <u>Buhl Idaho</u>	Residence (Usual place of abode) <u>Buhl Idaho</u>
--	--

If nonresident, give place and State	If nonresident, give place and State
--	--

Color or race <u>W</u> Age at last Birthday <u>25</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>33</u> (Years)
---	---

Birthplace <u>Fading Utah</u> (City and State or Country)	Birthplace <u>Delta Colo</u> (City and State or Country)
--	---

Occupation <u>farmer</u>	Occupation <u>housewife</u>
--------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 7:20 P. M.

(Signature) H. E. Lamb

(Physician or midwife)

Address Twin Falls Idaho

Filed 11:30 1929 D. D. McCaughey
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1

1000

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

366-108-042-133
PLACE RECEIVED DEC 11 1929
County of Iron
City of Iron
No. 235 Janey St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

176647

Registration District No. 37 State File No. _____

Prim. Registration District No. 1085 Local Registrar's No. _____

(If born in hospital or institution
give name.)

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins Triplet or other? _____	and {	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>11-8-</u> <u>1929</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 6 (a) Born alive and now living 3

Born alive but now dead 2 Stillborn 1

FATHER FULL NAME <u>Roy L. Lons</u>	MOTHER FULL MAIDEN NAME <u>Elizabeth Allen</u>
--	---

Residence (Usual place of abode) Iron Falls

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 24 (Years)

Birthplace Kansas (City and State or Country)

Occupation Farmer

Residence (Usual place of abode) Iron Falls

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 25 (Years)

Birthplace Kansas (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

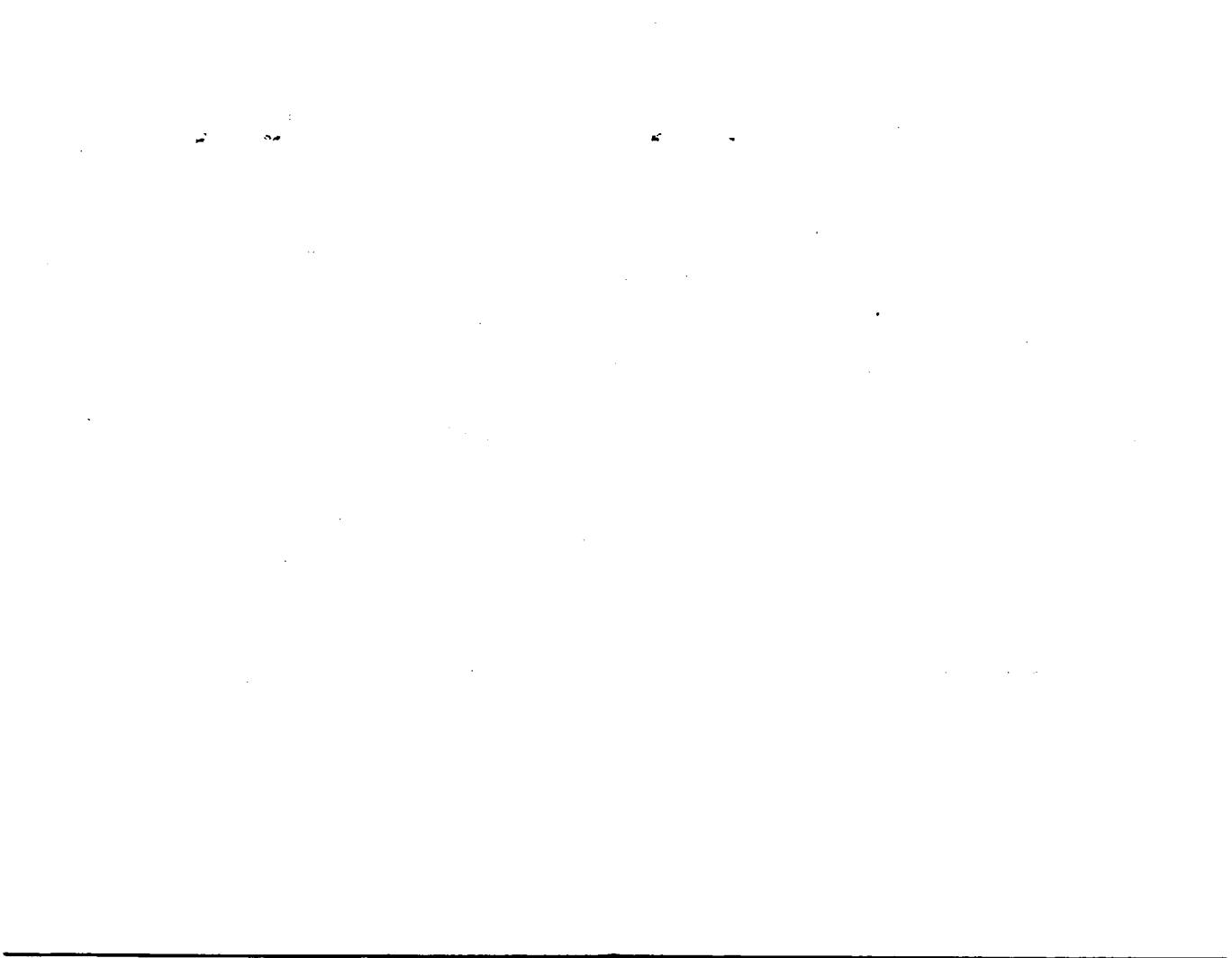
I hereby certify that I attended the birth of this child, who was {~~Born alive~~
Stillborn } at 1:48 P M.
on the date above stated.

(Signature) W. N. Lutes

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Physician or midwife)
Address Iron Falls, Idaho

Filed 11:30 1929 D. M. Courree
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1929

PLACE OF DEATH

County of Blaine
City of Blaine

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.
Primary Registration District No.

DO NOT WRITE IN THIS SPACE
State File No. 68455

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward C. Lowe
(a) Residence. No. 253 Quincy St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 8 / 1929
7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still Born
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho
10. NAME OF FATHER RC Lowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant RC Lowe
(Address) Blaine Falls La.
15. Filed 11-23-29, 1929. Dr. D. M. Courque Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 8 1929
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11-8-, 1929, to 11-8-, 1929, that I last saw him alive on 11-8-, 1929 and that death occurred, on the date stated above, at 12:40 p.m. The CAUSE OF DEATH* was as follows:
Still born

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? not known
Did an operation precede death? m Date of
Was there an autopsy? m
What test confirmed diagnosis?
(Signed) W. H. Keety, M. D.
11-9-, 1929 (Address) Blaine Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal Blaine Falls Date of Burial Nov 9 1929
20. Undertaker J. H. Drake Address Blaine Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

466-129.00-392
PLACE OF BIRTH
RECEIVED JAN 8

County of Boise
City of Boise
No. 318 St. St. Alphonsus

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 176750

Registration District No. 2 State File No. 540

Prim. Registration District No. 1004 Local Registrar's No. 540

FULL NAME OF CHILD 7 1/2 months later -
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>m.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 29</u> (Month) (Day) (Year) <u>19 29</u>
------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead no Stillborn yes

FATHER
FULL NAME Frank Lee Downey

Residence (Usual place of abode) Boise

If nonresident, give place and State Ida

Color or race w Age at last Birthday 36
(Years)

Birthplace Colo
(City and State or Country)

Occupation Miner

MOTHER
FULL MAIDEN NAME Ethel Lee Cison

Residence (Usual place of abode) Boise

If nonresident, give place and State Ida

Color or race w Age at last Birthday 33
(Years)

Birthplace Colo
(City and State or Country)

Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 9-40 M.

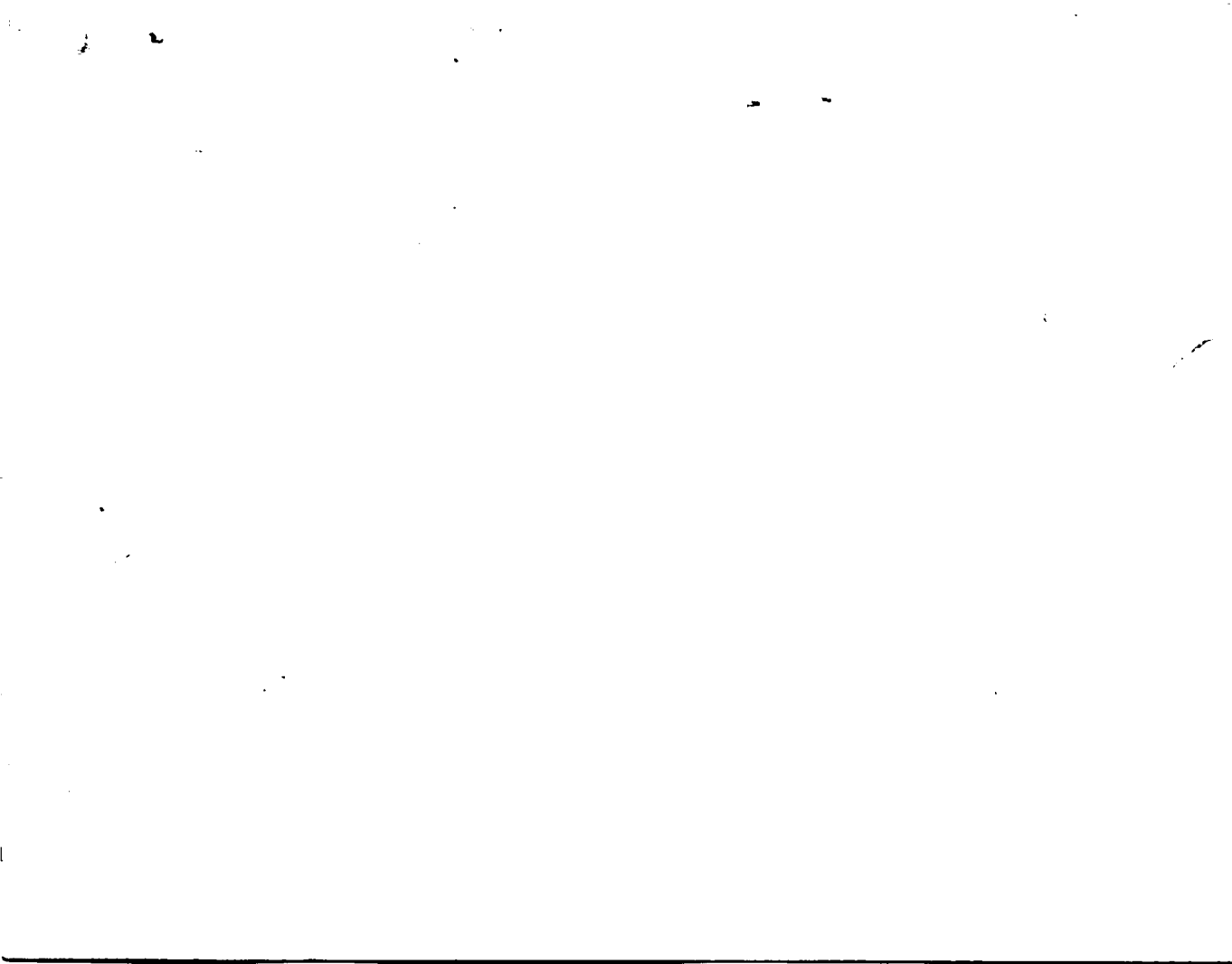
(Signature) John Bank

(Physician or midwife)

Address Boise

Filed 12-31 1929 W. J. Rhodes
R. L. Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68157

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 305

2. FULL NAME Baby Downey.

(a) Residence. No. 1318 Ada St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 29th 1929

7. AGE Years Months Days If LESS than 1 day, min. 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho. (State or country)

10. NAME OF FATHER Frank Downey.

11. BIRTHPLACE OF FATHER (city or town) Colorado. (State or Country)

12. MAIDEN NAME OF MOTHER Ethel Cissne.

13. BIRTHPLACE OF MOTHER (city or town) Colorado. (State or Country)

14. Informant Frank Downey. (Address) 1318 Ada St. Boise, Ida.

15. Filed 11-29-29 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 29-1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929, to Nov 29, 1929 that I last saw him alive on Nov 29, 1929 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: Death occurred in utero.

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 11/29/29 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 11/30/29

20. Undertaker Wm. Mc Bratney. Address Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

957-1101-001-152
PLACE OF BIRTH

Form V. S. No. 11—20m-7-28-19

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

176766

County of Ada..... Registration District No. File No.
 City of Kuna..... St.
 No. Primary Registration District No. Registered No. 66
 Hospital
 FULL NAME OF CHILD Robert Rexroad.....

Sex of Child Male. {Twin Triplet or other? } and {Number in order of birth } Legiti-
 mate? Yes. Date of Birth 12 10 1929
 (Month) (Day) (Year)
 (To be answered only in event of plural births)

FATHER		MOTHER	
FULL NAME	<u>Harry A. Rexroad</u>	FULL MAIDEN NAME	<u>Grace Jesse</u>
RESIDENCE	<u>Kuna, Idaho</u>	RESIDENCE	<u>Kuna, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>45</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Kansas</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

Number of child of this mother, including present birth Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 45 P. M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Physician

(Physician or midwife)

Kuna, Idaho

Address

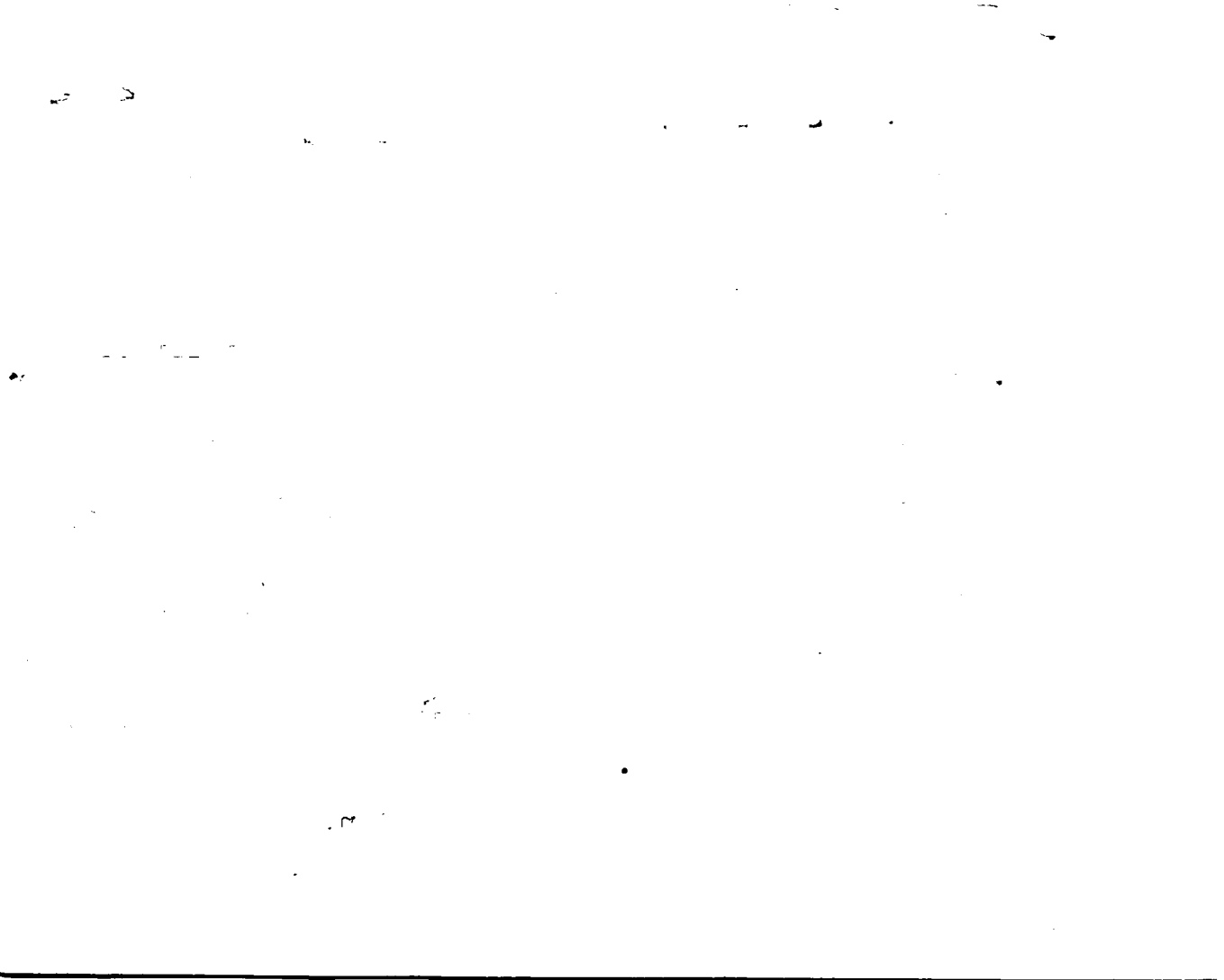
Given names added from a supplemental report.

19.....

Filed 12-18 1929 Ray Musselman

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68541

County of Ada Registration District No. _____
City of Kuna Primary Registration District No. _____
(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 199

206

2. FULL NAME Robert Rexroad

(a) Residence. No. Kuna, Idaho St. _____

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Stillborn
Dec. 10 - 1929

7 AGE Years Months Days
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Kuna, Idaho
(State or country)

10 NAME OF FATHER Harry A. Rexroad
11 BIRTHPLACE OF FATHER (city or town) Kansas
(State or country)
12 MAIDEN NAME OF MOTHER Grace Jessee
13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Mrs. Grace Rexroad, Mother
(Address) Kuna, Idaho

15 Filed 12-18, 1929 R. J. Muselman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 10 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at 4-45 P. m.

The CAUSE OF DEATH* was as follows:

Utero-placental Apoplexy, Being
(Stillborn).
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? No
What test confirmed diagnosis? before forceps were applied.
(Signed) F. J. Coleman, M. D.
Dec 11, 1929 (Address) Kuna, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

354-108-1002-K-2
PLACE RECEIVED
DEC 18 1929
County of Bannock
City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. Pocatello 691 St. _____
Registration District No. 28 State File No. 176805
born in hospital or institution
give name.) Prim. Registration District No. 216 Local Registrar's No. 9527

FULL NAME OF CHILD "Stillbirth"
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M Twin Triplet or other? and Number in order of birth Legitimate? Yes Date of birth Nov. 8 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Guy L. Lemmon</u>	FULL MAIDEN NAME <u>Emma C. Ausmug</u>
Residence (Usual place of abode) <u>Pocatello</u>	Residence (Usual place of abode) <u>Pocatello</u>
If nonresident, give place and State _____	If nonresident, give place and State <u>Idaho</u>
Color or race <u>White</u> Age at last Birthday _____ (Years)	Color or race <u>White</u> Age at last Birthday <u>28</u> (Years)
Birthplace <u>Millcreek Utah</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Radio Business</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 5:30 P. M.
on the date above stated.

(Signature) L. Ray

(Physician or midwife)

Address Pocatello

Filed 12/1 1929 W. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

JUN 1 1971

RECEIVED DEC 18 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68550

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5698

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Lemon Lemmon

(a) Residence. No. Poca. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 9, 1929.

7. AGE Years Months Days If LESS than 1 day,
0 0 0 Still hrs. or
Born min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Idaho.
(State or country)

10. NAME OF FATHER

G. L. Lemon Lemmon

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

Emma Ausmus

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Pine City, Minn.

14. Informant G. L. Lemon Lemmon
(Address) Tyhee, Idaho.

15. Filed 11/12, 1929 J. L. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 8, 1929.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19

that I last saw h. alive on , 19

and that death occurred, on the date stated above, at.

The CAUSE OF DEATH* was as follows:

Premature 26 weeks
Eclampsia in mother

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 11-12, 1929 J. L. Young, M. D.
(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Mountain View Cemetery 11/12/29. 19

20. Undertaker Arthur W. Hall Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

546 116.004-219
PLACE OF BIRTH Beaumont JAN 14 1930

County of Beaumont
City of Beaumont

No. St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 52 State File No. 176860

Prim. Registration District No. 2136 Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Boy Twin Triplet or other? and Number in order of birth 1 Legitimate? 1/8 Date of birth 11 16 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth 2 (a) Born alive and now living one

Born alive but now dead one Stillborn one

FATHER
FULL NAME Edward
Residence (Usual place of abode) Beaumont

If nonresident, give place and State

Color or race white Age at last Birthday 28 (Years)

Birthplace Idaho (City and State or Country)

Occupation farmer

MOTHER
FULL MAIDEN NAME Leon B. Barrington
Residence (Usual place of abode) Beaumont

If nonresident, give place and State

Color or race white Age at last Birthday 28 (Years)

Birthplace Idaho (City and State or Country)

Occupation supervisor

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 4 P M.
on the date above stated.

(Signature) Dr. J. L. Lively

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address 1231

Filed 1929 Registrar.

W
D

RECEIVED FEB 8 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

JAN 8 1930

176860

Mrs. HJ Edwards
Montpelier

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD This child received no name as it was born dead.

PLACE OF BIRTH** Montpelier DATE OF BIRTH Nov. 16, 1929 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 2
2. Number born alive and now living 1
3. Born alive but now dead 1
4. Number of children stillborn One born dead

(Please write plainly)

Information with reference to

FATHER

Herbert J. Edwards

(Full name)

Montpelier, Idaho

(Residence)

Age at last birthday 22

Thayne Wyoming

(Birthplace)

Common laborer

(Occupation)

Information with reference to

MOTHER

Leona Barrington

(Full Maiden name)

Montpelier, Idaho

(Residence)

Age at last birthday 21

Riverdale Idaho

(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED JAN 8 1930
County of Blaine
City of Riverside

No. 445 705 006 813 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

176912

Registration District No. 121 State File No. 392

Prim. Registration District No. 2194 Local Registrar's No. 392

FULL NAME OF CHILD Junior Dunnick

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Male Child	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimacy Yes mate?	Date of birth December 5 1929 (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? 15% Neo-Silver

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Charles A. Dunnick
Residence (Usual place of abode) Riverside
If nonresident, give place and State.
Color or race White Age at last Birthday 23
(Years)
Birthplace Washington
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Grace Leila Hall
Residence (Usual place of abode) Riverside
If nonresident, give place and State
Color or race White Age at last Birthday 21
(Years)
Birthplace Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:00 A. M.
on the date above stated.

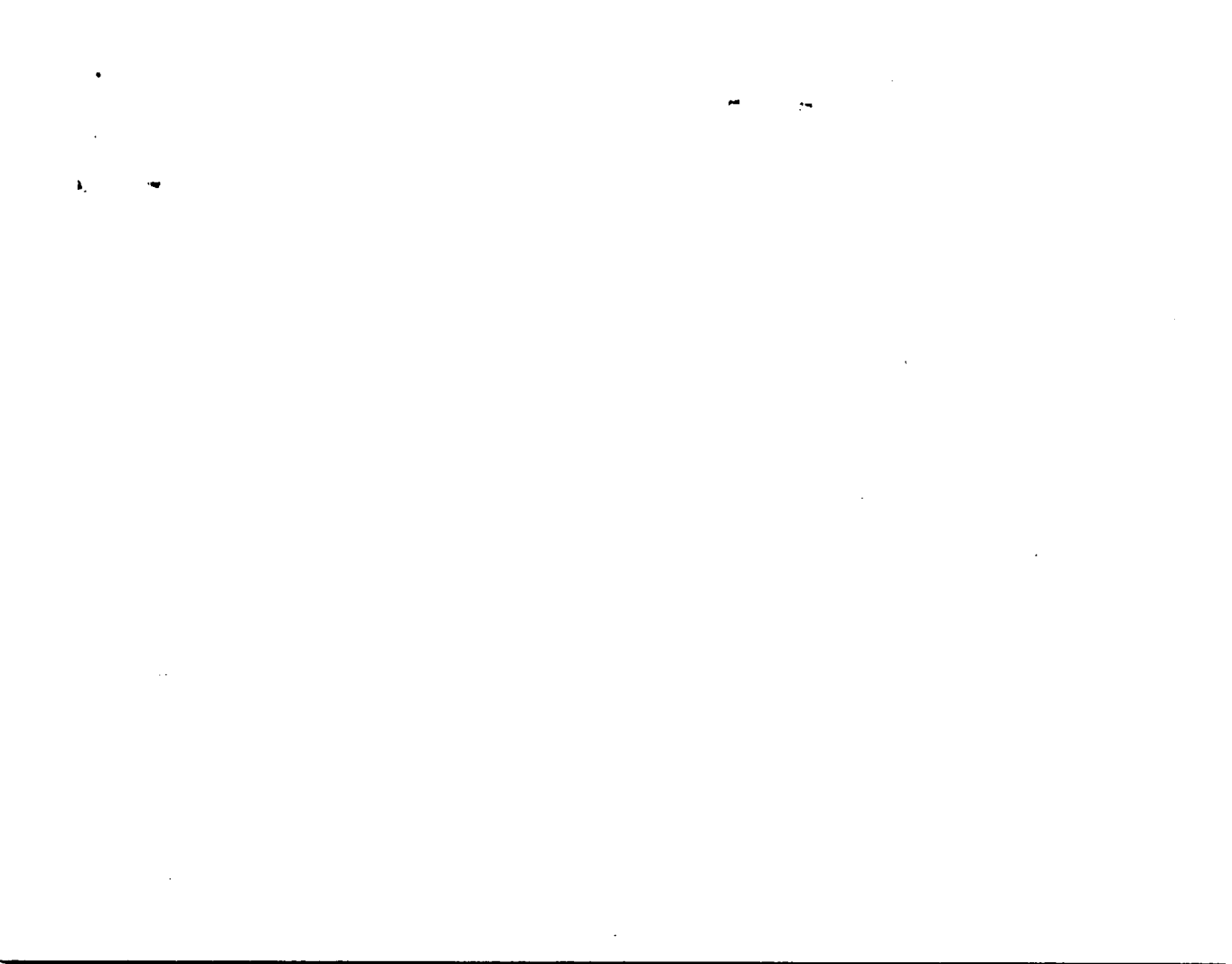
(Signature) J. O. Hampton M.D.

(Physician or midwife)

Address Blackfoot Idaho

Filed Jan 6 1930 Wm. E. Patton Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

176912

RECEIVED JAN 8 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68632

County of Bingham
City of Blackfoot.

Registration District No. 181
Primary Registration District No. 2194+1007

Local Registrar's No. 212

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dunnick
(a) Residence. No. Riverside St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

206

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) Dec. 5, 1929		
7. AGE	Years	Months
	0	0
		Days
		0
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work.		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (city or town) (State or country)	<u>Blackfoot B. 2</u>
10. NAME OF FATHER	Chas. Dunnick
11. BIRTHPLACE OF FATHER (city or town) (State or Country)	
12. MAIDEN NAME OF MOTHER <u>Hall</u>	Grace Dunnick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)	<u>Utah</u>

14. Informant* <u>C. S. Hall</u>	
(Address) <u>Blackfoot, Id.</u>	
15. Filed <u>Dec 6 24 Min</u>	<u>Walter E. Patrie</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH	Dec. 5, 1929.		
(Month)	(Day)	(Year)	
17. I HEREBY CERTIFY, That I attended deceased from <u>12-5</u> , 19 <u>29</u> , to <u>19</u> , that I last saw h. <u>alive</u> on <u>19</u> , and that death occurred, on the date stated above, at <u>9:00</u> m. The CAUSE OF DEATH* was as follows: <u>Still born</u>			
(duration)	yrs.	mos.	ds.

CONTRIBUTORY (Secondary)	(duration)	yrs.	mos.	ds.
18. Where was disease contracted if not at place of death? <u>✓</u>				
Did an operation precede death? <u>✓</u>	Date of <u>✓</u>			
Was there an autopsy? <u>✓</u>				
What test confirmed diagnosis? (Signed) <u>J. O. Humphreys</u> , M. D. <u>12-6</u> , 19 <u>29</u> (Address) <u>Blackfoot, Id.</u>				

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	12-7-29 19
20. Undertaker	Address
Modern Furn. & Mortuary Bft.	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLA RECEIPT JAN 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine
City of Harley

CERTIFICATE OF BIRTH

176945

No. 84
919-205-017 433

(If born in hospital or institution
give name.)

Registration District No. 57 State File No. 2

Prim. Registration District No. 2022 Local Registrar's No. 78

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>Yes</u>	Date of birth <u>1 2 5</u> (Month) (Day) (Year)	<u>19 29</u>
-------------------------------	---	---	----------------------------	---	--------------

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead — Stillborn 1

FATHER
FULL NAME David E. Morris

Residence (Usual place of abode) Harley, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 33

Birthplace Ketchum, Ida (City and State or Country)

Occupation Miner

MOTHER
FULL MAIDEN NAME Mary J. McFoy

Residence (Usual place of abode) Harley, Ida

If nonresident, give place and State

Color or race White Age at last Birthday 29

Birthplace Ketchum, Ida (City and State or Country)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive } at 2 30 a. M.
Stillborn }
on the date above stated.

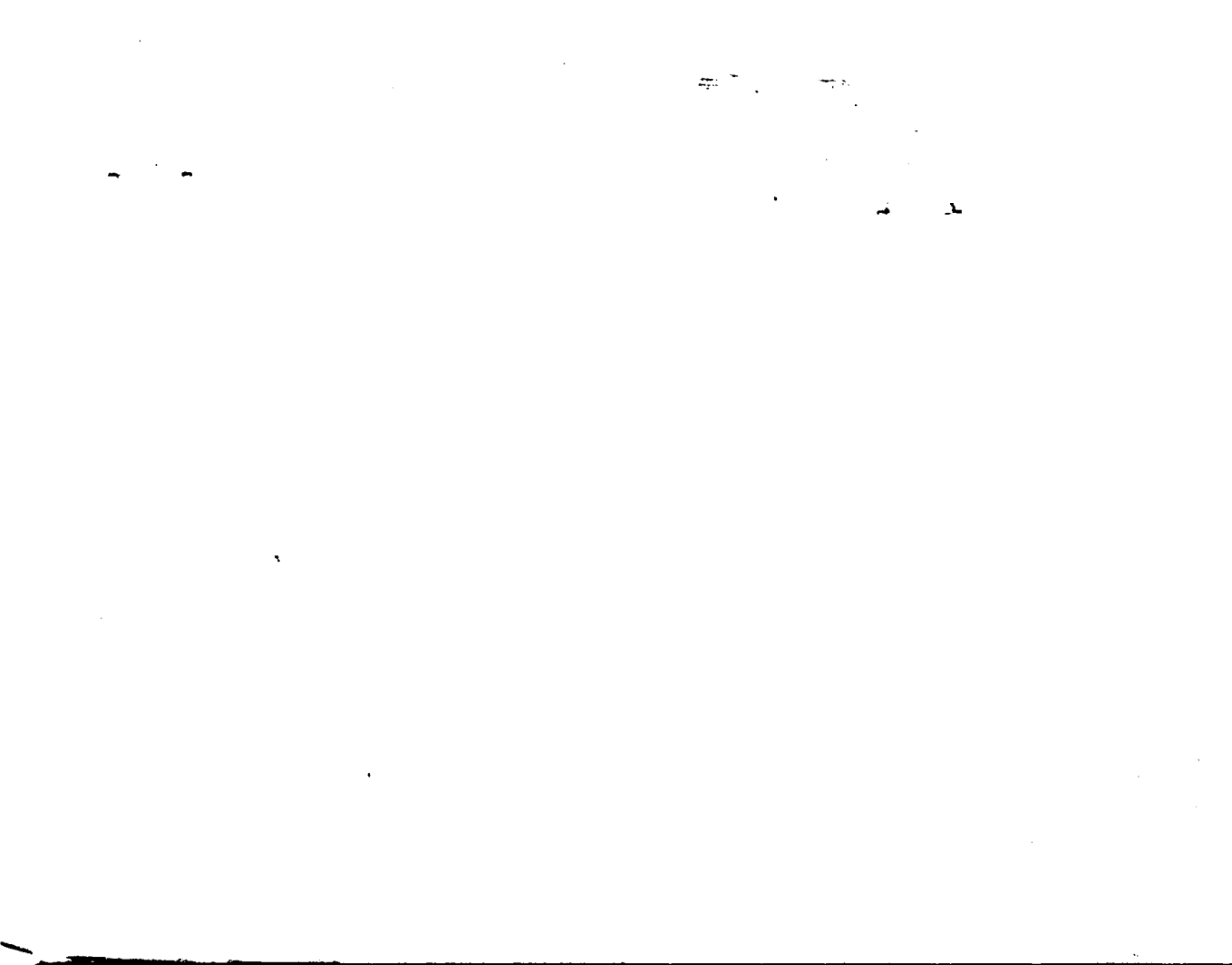
(Signature) Physician

(Physician or midwife)

Address Harley, Ida

Filed 12-10-19 29 Phat H. Wright Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED JAN 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68641

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 44

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Morris

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hailey, Ida (State or country)

10. NAME OF FATHER David L. Morris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pinedale, Ida

12. MAIDEN NAME OF MOTHER Mary J. McFay

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pinedale, Ida

14. Informant Mrs. D. F. Morris (Address) Hailey, Ida

15. Filed 12-10, 1929 R. H. Wright-Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12/5/29 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/2/29, 1929, to 12/5/29, 1929, that I last saw him alive on 12/5/29, 1929, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Still born - Placental hemorrhage from rough.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. W. F. M. D.

12/5/29 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hailey, Ida Date of Burial 12-5-29

20. Undertaker Amos + Harris Hailey Address

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED
PLACE OF BIRTH JAN 6 1930

County of Bonner
City of Sandpoint
No. 597115009 363 St.
Jarnell Hospital
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 78 State File No. 176952
Prim. Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	<u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>Yes</u>	Date of birth <u>December 15th 19 29</u> (Month) (Day) (Year)
--------------	-------------	---	--------------------------------------	----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3rd. (a) Born alive and now living TWO
Born alive but now dead None Stillborn One

FATHER
FULL NAME Maurice Vigne
Residence (Usual place of abode) _____
If nonresident, give place and State _____
Color or race White Age at last Birthday 23
(Years)
Birthplace Westmond Idaho.
(City and State or Country)
Occupation Logger

MOTHER
FULL MAIDEN NAME Pearlie Cotter
Residence (Usual place of abode) Sandpoint, Idaho.
If nonresident, give place and State _____
Color or race White Age at last Birthday 19
(Years)
Birthplace Sandpoint, Idaho.
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 4.30 A. M.

(Signature) A. W. Evans

Physician

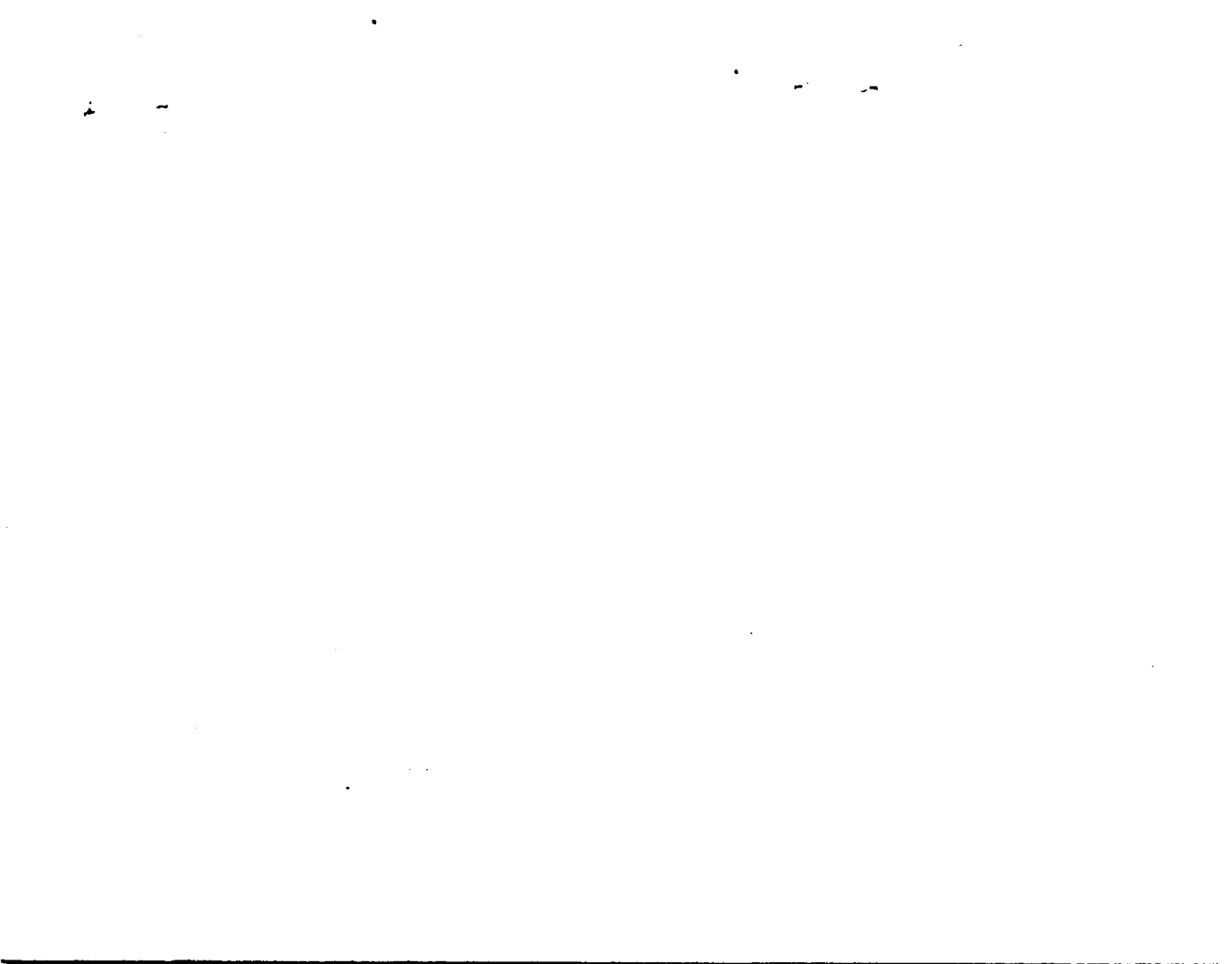
(Physician or midwife)

Address Sandpoint, Idaho.

Filed 1-3 1930 Floyd A. Wendt

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

176492 +

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68651

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 206

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Vigue

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 15, 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER Morris Vigue

11. BIRTHPLACE OF FATHER (city or town) Sandpoint
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Pearlie Cotter

13. BIRTHPLACE OF MOTHER (city or town) Sandpoint
(State or Country) Idaho

14. Informant Morris Vigue
(Address) Sandpoint, Idaho

15. Filed 1-3 1930 Floyd G. Woodie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 15 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1929 to 1929,
that I last saw him alive on Stillborn, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Premature detachment
of placenta
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? A. P. Graves
(Signed) 12-16, 1929 (Address) Sandpoint, Idaho M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lincrest Cemetery, Inc. Date of Burial 1929

20. Undertaker Moon Mortuary, Sandpoint, Idaho Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

696-225 C/O 793

PLACED RECORDED DEC 19 1929

County of Bonneville

City of Idaho Falls

No. _____ St.

L. D. S. Hospital

(If born in hospital or institution
give name.)

FULL NAME OF CHILD _____

Registration District No. 73 State File No. _____

Local Registrar's No. 492

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Female	Twins Triplet or other?	{ and }	Number in order of birth	Legitimate?	Yes	Date of birth	11	25	19	29
(To be answered only in event of plural births)					(Month) (Day) (Year)						

What prophylactic was used to prevent Ophthalmia Neonatorum? Arygrol 20%

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Allen Fifield</u>	FULL MAIDEN NAME <u>Eva Pilkington</u>
Residence (Usual place of abode) <u>Idaho Falls</u>	Residence (Usual place of abode) <u>Idaho Falls</u>
If non-resident, give place and State _____	If non-resident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>32</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>27</u> (Years)
Birthplace <u>Weston, Idaho</u> (City and State or County)	Birthplace <u>Smithfield, Utah</u> (City and State or County)
Occupation <u>Music Teacher</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:15 A. M.
on the date above stated.

(Signature) _____

Physician
(Physician or midwife)

Address Idaho Falls, Idaho

Filed Jan 2 1925 _____
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration Number No. _____

Local Health Officer No. _____

IT is hereby certified that on _____

_____ at _____

_____ the _____

_____ of _____

_____ was born _____

_____ to _____

_____ and _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS1. ~~PLACE OF DEATH~~ **DEC 19 1929**County of BonnevilleRegistration District No. 23City of Idaho FallsPrimary Registration District No. 2100(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still BornState File No. 68671Local Registrar's No. 221

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDW

(Write the word)

6. DATE OF BIRTH

11-25-29

(Month)

(Day)

(Year)

7. AGE

StillbornIF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls, Ida.

10. NAME OF

Father

Allen T. Field11. BIRTHPLACE
OF FATHER(State or Country) Wilson, Ida.12. MAIDEN NAME
OF MOTHEREva Pilkington13. BIRTHPLACE
OF MOTHER(State or Country) Smithfield, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allen T. Field

(Address)

Idaho Falls

15.

Filed

11/291929

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

In utero
Before Nov 25

(Month)

(Day)

1929
(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

Nov. 25 1929 to Nov. 25 1929that I last saw him alive on Nov 25 1929and that death occurred on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:

In utero.Premature Birth
7 mo

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)schistocera plaventa

(Duration)

yrs.

mos.

ds.

(Signed)

11/27/29

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Cremation as

DATE OF BURIAL

19

20. UNDERTAKER

none
L.D.S. Hosp

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE RECORD IN DEPT. 19 1929
County of Bonanza
City of Lincoln
No. 666-125 010-371 State Idaho District No. 2150 State File No. 177010
(If born in hospital or institution give name.)
Prim. Registration District No. 2150 Local Registrar's No. 474
FULL NAME OF CHILD Unnamed
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>yes</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov. 25</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? none
Number of child of this mother, including present birth 2 (a) Born alive and now living none
Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>John W. Woolsey</u>	FULL MAIDEN NAME <u>Grace Crain</u>
Residence (Usual place of abode) <u>Lona, Idaho</u>	Residence (Usual place of abode) <u>Lona, Idaho</u>
If non-resident, give place and State <u>—</u>	If non-resident, give place and State <u>—</u>
Color or race <u>White</u> Age at last Birthday <u>33</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Utah</u> (City and State or County)	Birthplace <u>St Anthony, Idaho</u> (City and State or County)
Occupation <u>Section hand</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:45 P. M. on the date above stated.
(Signature) A. M. Overhart
M. D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Idaho Falls, Idaho
Filed Nov. 27 1929 C. J. Quinn
Registrar.

RECEIVED FEB 3 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

JAN 28 1930

Boise, Idaho

177010

Mrs. J.W. Woolsey
Lona, Ida.

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

PLACE OF BIRTH** Lincoln, Ida. DATE OF BIRTH Nov. 25, 1929 SEX OF CHILD Male

1. Number of children born to this mother, including present birth 2
2. Number born alive and now living none
3. Born alive but now dead one
4. Number of children stillborn one

(Please write plainly)

Information with reference to
FATHER

John William Woolsey
(Full name)
Lona, Idaho
(Residence)

Age at last birthday 34
Doune, Idaho
(Birthplace)
Labor
(Occupation)

Information with reference to
MOTHER

Grace Norma Crui
(Full Maiden name)
Lona, Idaho
(Residence)

Age at last birthday 20
New Hope Idaho
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey
C.K. Macey

Special Agent, Bureau of the Census.

869-112-014-761

RECEIVED JAN 13 1930
PLACE OF BIRTH

Form V. S. No. 11-C—25m-1-1-18

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 177073

County of _____

City of _____

Registration District No. _____

File No. _____

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Not named Stillborn

Sex of Child

Male

Twin
Triplet
or other?

Other

Number in order of birth

3rd

Legitimate?

Yes

Date of Birth

Dec 12 1929
(Month) (Day) (Year)

FULL NAME

Conrad R. York

FATHER

RESIDENCE

Caldwell Ida

COLOR

White

AGE AT LAST BIRTHDAY

34 (Years)

BIRTHPLACE

Georgia

OCCUPATION

Farmer

FULL MAIDEN NAME

Mary Marie Phillips

MOTHER

RESIDENCE

Caldwell Ida

COLOR

White

AGE AT LAST BIRTHDAY

24 (Years)

BIRTHPLACE

Connetts Ida

OCCUPATION

House wife

Number of child of this mother, including present birth

Three

Number of children of this mother now living, including present birth

2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

Stillborn
(Born alive or stillborn)

at 3:30 A.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. M. Henry

(Physician certificate)

Given names added from a supplemental report.

Address

Notus Ida

Filed

12-30-1929

John S. Meyers
Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

PLACE OF DEATH

County of Canyon
City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 68693

Local Registrar's No. 136

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby York

(a) Residence. No. 101 St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 12-29

7. AGE Years Months Days Still born If LESS than 1 day: Dead at birth hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idiwe
(State or country)

10. NAME OF FATHER C. R. York

11. BIRTHPLACE OF FATHER (city or town) Georgia
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Phillips

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant C. R. York
(Address) Caldwell, Idaho. Reg.?

15. Filed 12-13, 1929. John H. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 12 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Long hard labor

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Yes Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Henry M. D.
Dec. 13, 1929 (Address) Natue Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill Date of Burial Dec 13 1929

20. Undertaker Paul L. Case Address Caldwell, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED FEB 4 1930

DIVISION OF
VITAL STATISTICSDEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICSC.K. MACEY
SPECIAL AGENT

Boise, Idaho

JAN 20 1930

177073

Mrs. C. York
CaldwellBIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Baby York

PLACE OF
BIRTH** CaldwellDATE OF
BIRTH

Dec. 12, 1929

SEX OF
CHILD Male

1. Number of children born to this mother, including present birth three
2. Number born alive and now living two
3. Born alive but now dead one Born Dead
4. Number of children stillborn two

(Please write plainly)

Information with reference to

FATHER

Conrad Ray York

(Full name)

Caldwell Idaho

(Residence)

Age at last birthday

34

Clayton G.A.

(Birthplace)

Flames

(Occupation)

Information with reference to

MOTHER

Mary Louis Phillips

(Full Maiden name)

Caldwell Ida.

(Residence)

Age at last birthday

24

Emmett Idaho

(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey

Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH JAN 13 1930

County of Cassia
City of Builey
No. _____ St. _____

168 21006-524
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

177156

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>13 - 10 - 1929</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living 1
Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Raymond Johnson
Residence (Usual place of abode) Builey
If nonresident, give place and State _____
Color or race W Age at last Birthday 28 (Years)
Birthplace Ut
(City and State or Country)
Occupation Farming

MOTHER
FULL MAIDEN NAME Elin Julia Ekman
Residence (Usual place of abode) Builey
If nonresident, give place and State _____
Color or race W Age at last Birthday 23 (Years)
Birthplace Sweden
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 a. M.
on the date above stated.

(Signature) E. F. Culler
MD.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Builey Ida
Filed 1 - 2 1930 F. F. Culler
Registrar.

CHILD OF CHILD

11. 11. 1941

RECEIVED 90 OCT 31 1983

STATE OF NEW YORK
SOUTHERN DISTRICT OF NEW YORK

(S) He is said not to "talk" but to "show" his attitude.

[illegible]

What procedure was used to derive the following information?

1. The first part of the document is a list of names and addresses, which appears to be a directory or a list of contacts. The names are written in a cursive script, and the addresses are listed below them. The list includes names such as "John A. Smith", "John B. Smith", "John C. Smith", "John D. Smith", "John E. Smith", "John F. Smith", "John G. Smith", "John H. Smith", "John I. Smith", "John J. Smith", "John K. Smith", "John L. Smith", "John M. Smith", "John N. Smith", "John O. Smith", "John P. Smith", "John Q. Smith", "John R. Smith", "John S. Smith", "John T. Smith", "John U. Smith", "John V. Smith", "John W. Smith", "John X. Smith", "John Y. Smith", and "John Z. Smith".

100-443887-100

SECRET

SECRET

[Faint, illegible text from bleed-through]

_____ (Date of Birth) _____ (Date of Birth)

It is recommended that the following be done:

CONFIDENTIAL

[Faint, illegible text at the bottom of the page]

(City and State of Country)

OFFICE OF ATTENDING PHYSICIAN ON BOARD

18 ()

SECRET

*Where there was no attending physician

of midwife, then the latter, householder, to be allowed to be admitted.

44-38861-1000

... ..

10-10-68

10. *Journal of the American Medical Association*, 277:1233-1234, 1996

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Clearwater JAN 6 1930 STATE OF IDAHO
County of Clearwater DEPARTMENT OF PUBLIC WELFARE
City of Boise BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 246204018863 St. 177171
(If born in hospital or institution give name.)
Registration District No. 90 State File No. 177171
Prim. Registration District No. 2187 Local Registrar's No. 98
FULL NAME OF CHILD Aaron Thelma Lucile Smolinska
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twins or other? <u>no</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>12-31-1929</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth one (a) Born alive and now living none
Born alive but now dead none Stillborn one

FATHER		MOTHER	
FULL NAME <u>Edward Smolinska</u>	FULL MAIDEN NAME <u>Ruth Lucile Holtett</u>		
Residence (Usual place of abode) <u>Boise</u>	Residence (Usual place of abode) <u>Boise</u>		
If nonresident, give place and State <u>none</u>	If nonresident, give place and State <u>none</u>		
Color or race <u>white</u> Age at last Birthday <u>25</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>20</u> (Years)		
Birthplace <u>Boise Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 120 M.
on the date above stated.

(Signature) W. H. Robinson

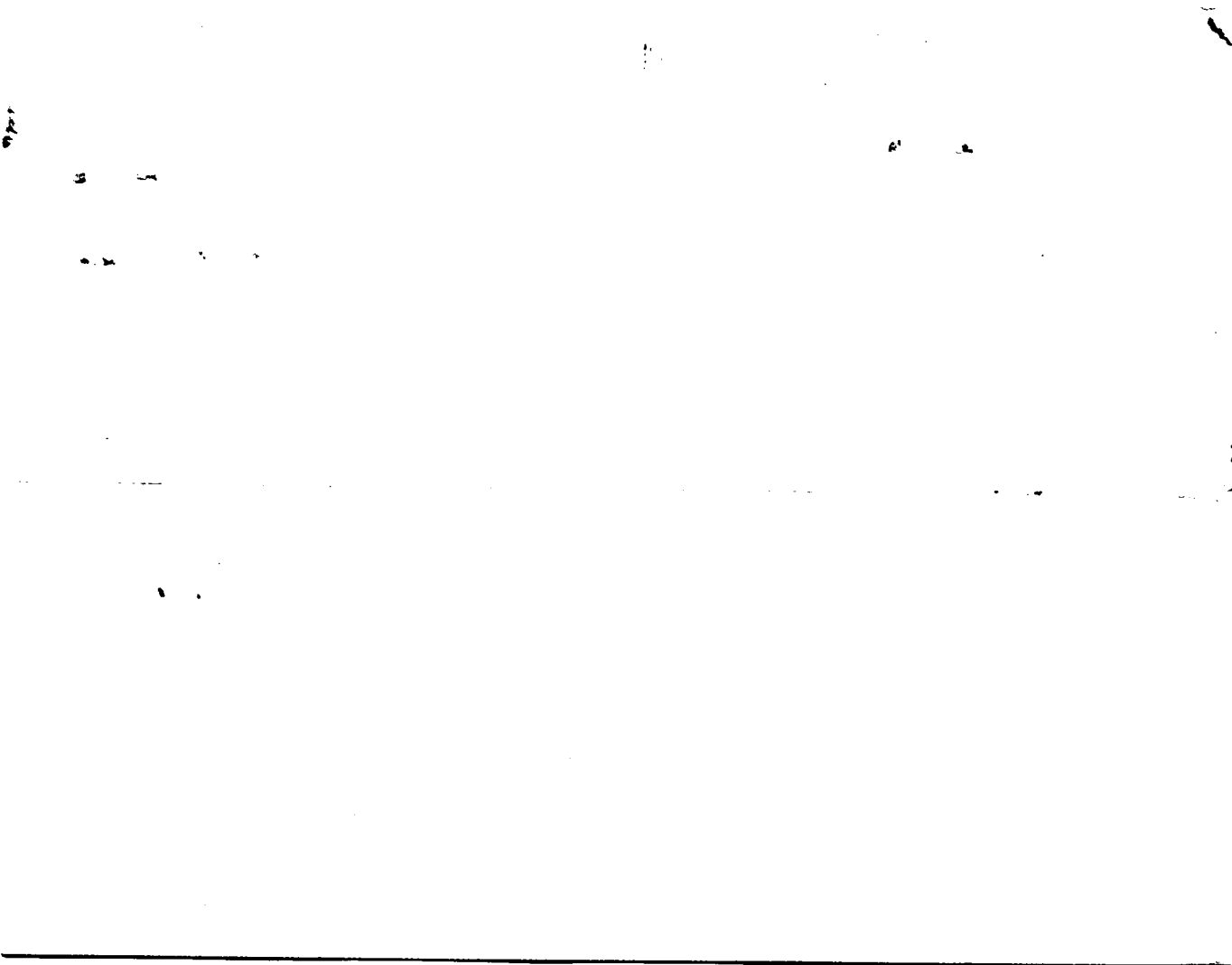
(Physician or midwife)

Address Boise Idaho

Filed 20 1929 W. H. Skow

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68724

PLACE OF DEATH

County of Clearwater
City of Greer, Ida

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 107

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Lucile Smolinski(a) Residence. No. 1 St. 206

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

15a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of1

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.1(b) General nature of industry,
business, or establishment in
which employed (or employer)1

(c) Name of employer

19. BIRTHPLACE (city or town)
(State or country)Greer, Ida

10. NAME OF FATHER

Edward Smolinski11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Greer, Ida

12. MAIDEN NAME OF MOTHER

Ruth Lucile Hattill13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Nebraska14. Informant
(Address)Edward Smolinski
Greer, Ida

15. Filed

Jan 36, 1929V. A. Khan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12429

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1, 1929, to 1, 1929that I last saw h 1 alive on 1, 1929and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Born dead, still birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? 1 Date of 1Was there an autopsy? 1

What test confirmed diagnosis?

(Signed)

Dr. Robert

M. D.

12/2912/29

(Address)

Greer, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Fraser CemeteryJan 5 1929

20. Undertaker

Address

Had no undertaker

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH JAN 6 1930

County of Franklin
City of Preston, Ida

No. 265-115-021-235 St.

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Still Born

(If stillborn, substitute the word "Stillbirth" for name of child)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S177221

Registration District No. 27 State File No. 2119

Prim. Registration District No. 2119 Local Registrar's No. 2119

Sex of Child	Male	Twin Triplet or other?	{ and }	Number in order of birth	Legitimate?	Date of birth	Dec 15 1929
				(To be answered only in event of plural births)	yes	(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? XX

Number of child of this mother, including present birth 13 (a) Born alive and now living 10

Born alive but now dead 2 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Arnald Kofoed</u>	FULL MAIDEN NAME <u>Etna Stephens</u>

Residence (Usual place of abode) Preston, Ida

If non-resident, give place and State

Color or race white Age at last Birthday 53 43
(Years) (Years)

Birthplace Weston, Ida Preston, Ida
(City and State or County) (City and State or County)

Occupation Laborer Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4 P. M.
on the date above stated.

(Signature) G. W. States

M.D.

(Physician or midwife)
Preston, Ida

Address Preston, Ida

FILED Jan 3, 1930

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Sex
 3. Date of birth
 4. Place of birth
 5. Name of mother
 6. Name of father
 7. Name of attending physician
 8. Name of household
 9. Name of street
 10. Name of city
 11. Name of state
 12. Name of country

City of _____
 County of _____
 State of _____
 Date of birth _____
 Sex _____
 Name of child _____

STATE OF _____
 DEPARTMENT OF _____
 BUREAU OF _____
 OFFICE OF _____
 DIVISION OF _____

Registration District No. _____
 Local Registration No. _____
 (If stillborn, indicate the word "stillborn" for name of child)
 Name of child _____
 Sex _____
 Date of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of household _____
 Name of street _____
 Name of city _____
 Name of state _____
 Name of country _____

I hereby certify that I attended the birth of this child, who was _____
 (Signature)
 Name of child _____
 Sex _____
 Date of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of household _____
 Name of street _____
 Name of city _____
 Name of state _____
 Name of country _____

I hereby certify that I attended the birth of this child, who was _____
 (Signature)
 Name of child _____
 Sex _____
 Date of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of household _____
 Name of street _____
 Name of city _____
 Name of state _____
 Name of country _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68745

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

BABY KOFOED

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. Single, Married, Widowed, or Divorced **single**

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) **Dec 15 1929**

7. AGE Years Months Days If LESS than 1 day, hrs. or min. **0 0**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **BABY**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Preston Idaho** (State or country)

10. NAME OF FATHER **Ornald Kefoed Weston**

11. BIRTHPLACE OF FATHER (city or town) **Weston Idaho** (State or Country)

12. MAIDEN NAME OF MOTHER **Etna Stephens**

13. BIRTHPLACE OF MOTHER (city or town) **Preston Idaho** (State or Country)

14. Informant **Ornald Kefoed**

(Address) **Preston**

15. Filed **Dec 17 1929** **G. P. Miller** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1929 to Dec 15 1929 that I last saw him alive on **Dec 15 1929**

and that death occurred, on the date stated above, at **1** m.

The CAUSE OF DEATH* was as follows:

Found dead at birth - Cause not able to determine - Child had been dead 48 hours or more - Child's eyes were pinching 15 hours at birth without clothing -

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted If not at place of death?

Did an operation precede death? **No** Date of

Was there an autopsy? **No**

What test confirmed diagnosis? **Clinical**

(Signed) **G. W. States** M. D.

Dec 16 1929 (Address) **Preston Ida**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Preston Dec 16 1929

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Semile," etc.); "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician); but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Franklin JAN 6 1930
City of Clifton, Ida

No. 493-211-021-243 St.
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 177224

Registration District No. 27 State File No.

Prim. Registration District No. 2119 Local Registrar's No.

FULL NAME OF CHILD Still Born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Dec II</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Argerol and Boric

Number of child of this mother, including present birth I (a) Born alive and now living 0

Born alive but now dead Stillborn

FATHER	MOTHER
FULL NAME <u>LeRoy Mills</u>	FULL MAIDEN NAME <u>Irene Butters</u>
Residence (Usual place of abode) <u>Clifton, Ida</u>	Residence (Usual place of abode) <u>Clifton, Ida</u>
It non-resident, give place and State	It non-resident, give place and State
Color or race <u>white</u> Age at last Birthday <u>30</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>27</u> (Years)
Birthplace <u>Lewiston, Utah</u> (City and State or County)	Birthplace <u>Cornish, Utah</u> (City and State or County)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 P.M. M.
on the date above stated.

(Signature) E. W. States

M.D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Preston
11/3/30

RECEIVED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68744

PLACE OF DEATH

County of Franklin

City of Clifton, Ida

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE white	5. Single, Married, Widowed, or Divorced (write the word) single
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5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of single

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work child(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Clifton, Ida
(State or country)

10. NAME OF FATHER LeRoy Mills

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Lewiston, Utah

12. MAIDEN NAME OF MOTHER Irene Butters

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Clarkston, Utah14. Informant LeRoy Mills
(Address) Clifton, Ida

15. Filed Dec 15, 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11, 1929, to Dec 11, 1929
that I last saw him before death

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Strangulation of Cord
in Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Second)7 waters in Primipara -
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. W. States, M. D.

Dec 12, 1929 (Address) Preston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Clarkston, Utah

Date of Burial

Dec 14 19

20. Undertaker

Hendricks

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED
PLACE OF BIRTH JAN 13 1930

County of Kootenai
City of Coeur d'Alene
No. 1620 Sherman St.
23 110 028 458

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
177399

Registration District No. 30 State File No. _____

Prim. Registration District No. 1650 Local Registrar's No. 237

FULL NAME OF CHILD Stillebirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct. 19</u> (Month) (Day)	<u>1929</u> (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? No Sil. oal. 10%

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Rex G. Stanton
Residence (Usual place of abode) Coeur d'Alene Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 38
(Years)
Birthplace Mich.
(City and State or Country)
Occupation meat cutter

MOTHER
FULL MAIDEN NAME Elizabeth Frances Meyer
Residence (Usual place of abode) Coeur d'Alene Idaho
If nonresident, give place and State _____
Color or race White Age at last Birthday 25
(Years)
Birthplace Id.
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5:30 A. M.
on the date above stated.

(Signature) J. C. Meyer

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Coeur d'Alene Idaho

Filed 12/29 1929 H. J. Sturgeon
Registrar.

18

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 4 1930

STATE OF IDAHO

County of Blaine

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Potlatch

CERTIFICATE OF BIRTH

S 177428

No. 791-217-000-895 St.

Registration District No. 65 State File No. 2145

(If born in hospital or institution give name.)

Prim. Registration District No. 2145 Local Registrar's No. 2145

FULL NAME OF CHILD Myrna Rose Grady

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin <input type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> and <input type="checkbox"/> Number in order of birth <input checked="" type="checkbox"/>	Legitimate? <u>yes</u>	Date of birth <u>Dec-17-1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth Five (a) Born alive and now living 0

Born alive but now dead 0 Stillborn one

FATHER

FULL NAME Earl Glen Grady

Residence (Usual place of abode) Calouse Wash.

If nonresident, give place and State ✓

Color or race white Age at last Birthday 27 (Years)

Birthplace Hennepin - Illinois
(City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Emma French

Residence (Usual place of abode) Calouse Wash

If nonresident, give place and State ✓

Color or race white Age at last Birthday 27 (Years)

Birthplace Liverpool - Ills.
(City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P M. on the date above stated.

(Signature) D. F. C. Gibson

(Physician or midwife)

Address Potlatch

Filed Dec. 18-1929 D. J. Pr. Thompson
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. ~~REPLACES~~ 5-25 M. 1-19.

JAN 4 1930

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Latah
City of Pottatch

Registration District No. 65
Primary Registration District No. 2145
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 88845
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Rae Grady

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Dec. 17 1929
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Pottatch Idaho

10. NAME OF FATHER

E. Glen Grady

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Emma French

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl G. Grady

(Address) Palouse Wash.

15.

Filled Dec-18th 1929

E. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th 1929, to Dec 17th 1929

that I last saw h. ✓ alive on ✓ 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born - from no known cause.

(Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory
(Secondary)

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) J. W. Thompson M. D.

7/18/1929 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted ✓
if not at place of death?

Former or usual residence ✓

19. PLACE OF BURIAL OR REMOVAL

Palouse Wash.

DATE OF BURIAL

Dec. 19th 1929

20. UNDERTAKER

E. Irwin

ADDRESS

Palouse

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

PLACE OF BIRTH

JAN 11 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lincoln
City of Shoshone

No. 958-116-032-275 St. -

(If born in hospital or institution
give name.)

CERTIFICATE OF BIRTH

Registration District No. 10-16 State File No. 177455

Prim. Registration District No. 51 Local Registrar's No. 51

FULL NAME OF CHILD Geo. Harvey Reynolds
(If stillborn, substitute the word "stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> }</u>	and <u> }</u>	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Dec 16</u> <u>1929</u> (Month) (Day) (Year)
--------------------------	--	---------------	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? -

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Floyd E. Reynolds</u>	MOTHER FULL MAIDEN NAME <u>Dorothy Speddy</u>
--	--

Residence (Usual place of abode) <u>Richfield</u>	Residence (Usual place of abode) <u>Richfield</u>
---	---

If non-resident, give place and State <u>-</u>	If non-resident, give place and State <u>-</u>
--	--

Color or race <u>White</u> Age at last Birthday <u>45</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>36</u> (Years)
---	---

Birthplace <u>Idaho</u> (City and State or County)	Birthplace <u>Idaho</u> (City and State or County)
--	--

Occupation <u>Mail carrier</u>	Occupation <u>Housewife</u>
--------------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1:30 PM on the date above stated.

(Signature) F. E. Barrett M.D.

(Physician or midwife)

Address -

Filed Jan 7 1930 J. L. Lauer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of the person: [illegible]
 2. Date of birth: [illegible]
 3. Place of birth: [illegible]
 4. Nationality: [illegible]
 5. Occupation: [illegible]
 6. Address: [illegible]
 7. Telephone: [illegible]
 8. Other: [illegible]

I have been informed that I attended the birth of this child on [illegible] at [illegible].
 I have been informed that I attended the birth of this child on [illegible] at [illegible].
 I have been informed that I attended the birth of this child on [illegible] at [illegible].

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 11 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68805

County of Lincoln
City of Shoshone

Registration District No. 16

Primary Registration District No. 20th

Local Registrar's No. 18

(No. Burdett Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years ✓	Months ✓	Days ✓
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Shoshone Idaho
(State or country)

10. NAME OF FATHER F E Reynolds
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jackson Mich
12. MAIDEN NAME OF MOTHER Dorothy Speedy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minneapolis Minn

14. Informant F E Reynolds
(Address) Richfield Idaho

15. Filed Dec 19 1929 J L Sweet Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 17 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1929 to Dec 17 1929
that I last saw him alive on 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No

What test confirmed diagnosis? Exam
(Signed) F E Reynolds, M. D.
Dec 15 1929 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Richfield Idaho
Date of Burial Dec 19 1929

20. Undertaker B E Hicks
Address Shoshone

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED FOR BIRTH JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce
City of Lewiston
No. _____ St. Registration District No. 96 State File No. 177539
Hospital St. Joseph's Hosp. Primary Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD Bernard Sline
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legiti- mate? No Date of birth Dec. 1 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER		MOTHER	
FULL NAME <u>Unknown</u>		FULL MAIDEN NAME <u>Bertha Augusta Sline</u>	
RESIDENCE _____		RESIDENCE <u>N. Lewiston, Ida.</u>	
COLOR _____	AGE AT LAST BIRTHDAY _____ (Years)	COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE _____		BIRTHPLACE <u>Ida.</u>	
OCCUPATION _____		OCCUPATION <u>none</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive { Stillborn } at 5²⁰ 1/2 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) B. E. Sline
(Physician or midwife)

Address Lewiston, Idaho

Filed Jan 1 1930 Simon E. Bruce
Registrar. Registrar.

OFFICE OF THE ATTORNEY GENERAL

21816 1712 04

Hospital _____ Physician _____
District _____

No _____

LEADS TO NAME OF CHINA

(Do not sign this Justice order on 7-6-80)

(1) The answers only, a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z.

Went back to the station and was told in 1967

"...member of child of the mother now living, including her own child."

Number of cases of this mother including present birth

FATHER

၂၂၀၃

197
197A .

NAME
MADAM
JULIA

20230:234

RECEIVED

00.00

AGE AT LAST
BIRTHDAY

8167164CE

ADA 1447418

OCCUPATION

14-00000

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

(4716-2500)

I hereby certify that I attended the birth of this child, who was stillborn.

on the date above stated.

Five names added from a supplemental report shows other evidence of the effort.

Give names added from a supplemental report.

1074-254H

Abstract

৯৫৭

501

1511000

Address - 28

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

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statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLATE RECORDED JAN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

177577

County of Blaine
City of Hoobrook
No. _____ St. _____

Registration District No. 26 State File No. _____

243 121 636 309
(If born in hospital or institution
give name.)

Prim. Registration District No. 3469 Local Registrar's No. 136

FULL NAME OF CHILD Joel Richard Smith
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	<input checked="" type="checkbox"/> Twin <input type="checkbox"/> Caplet or other?	and	<input type="checkbox"/> Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 21 1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillbirth

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn Yes

FATHER FULL NAME <u>Joel Allen Smith</u>	MOTHER FULL MAIDEN NAME <u>Ada Larsen</u>
---	--

Residence (Usual place of abode) Hoobrook Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 32 29
(Years)

Birthplace Fredonia Utah Coe Co Idaho
(City and State or Country) (City and State or Country)

Occupation Farmer Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3309 M.
on the date above stated.

(Signature) W. Dardleigh M.D.

(Physician or midwife)

Address Idaho Falls Utah

Filed 1/7/30 19 29 J. M. Tiers

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

STATE OF OHIO
COUNTY OF COLUMBIA
CITY OF COLUMBUS

REF ID: A66017

[illegible]

RETURN TO CHILD

1992

10-21-61

3354

What prophylactic was used to prevent infection?

Number of copies of this report, including all attachments, to be made available to the public is:

SECRET

(whole to early middle) ... whole to early middle

[illegible]

10-11-68

10-10-68

On the date above stated.

When there was no attending physician

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

"Where there was no attending physician or midwife, then the father, household head, or another male relative, or a neighbor, should make the return. A physician should be used if either parent or child is not in good health. This shows the importance of life after birth."

FORM V. S. No. 3-25 M. 1-19.

RECEIVED JAN 6 1930
PLACE OF DEATH

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Oneida*
City of *Stillbrook*Registration District No. *26*
Primary Registration District No. *2069*
(No. *37* St.)File No. *68898*
Registered No. *37*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joel Richard Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Nov 21 1929
(Month) (Day) (Year)

7. AGE

Stillbirth
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Stillbrook Ida

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Joel Allen Smith
Ft. Laramie Utah

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ada Lassen
Coe Cache Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Kern
*Stillbrook*15. Filed *1431* 19 *29* *J. M. Kern*
Local Registrar

16. DATE OF DEATH

Nov 21 1929
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 21 1929* to *Nov 21 1929* that I last saw him alive on *Stillbrook* 19 and that death occurred on the date stated above, at *3:30 A.M.*

The CAUSE OF DEATH* was as follows:

Stillbirth
Utero gestation 8 months
(Duration) Yrs. Mos. ds.
Contributory (Secondary) *Placenta previa*
hemorrhage ds.
(Duration) Yrs. Mos. ds.
(Signed) *W. E. Smith* M. D.
11/21 1929 (Address) *Stillbrook*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Stillbrook Ida**11/21 1929*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

177631

County of Teton
City of Driggs R.D.
No. 364-10-416-1 St. Registration District No. 77 State File No. 177631
Hospital _____ Primary Registration District No. 2176 Local Registrar's No. 62
FULL NAME OF CHILD Stillbirth

(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? + Date of birth 12/9 1929
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Boric 10-20Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FULL NAME FATHER

Carl A. Carlson

FULL MAIDEN NAME

MOTHER

Leah Haddad

RESIDENCE

Driggs, Ida. R.D.

RESIDENCE

Do.

COLOR

WAGE AT LAST BIRTHDAY 33
(Years)

COLOR

Do.AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE

Idyo.

BIRTHPLACE

Woh

OCCUPATION

Traveller

OCCUPATION

H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:40 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

L. T. T. Edwards, M. D.

(Physician or midwife)

Address

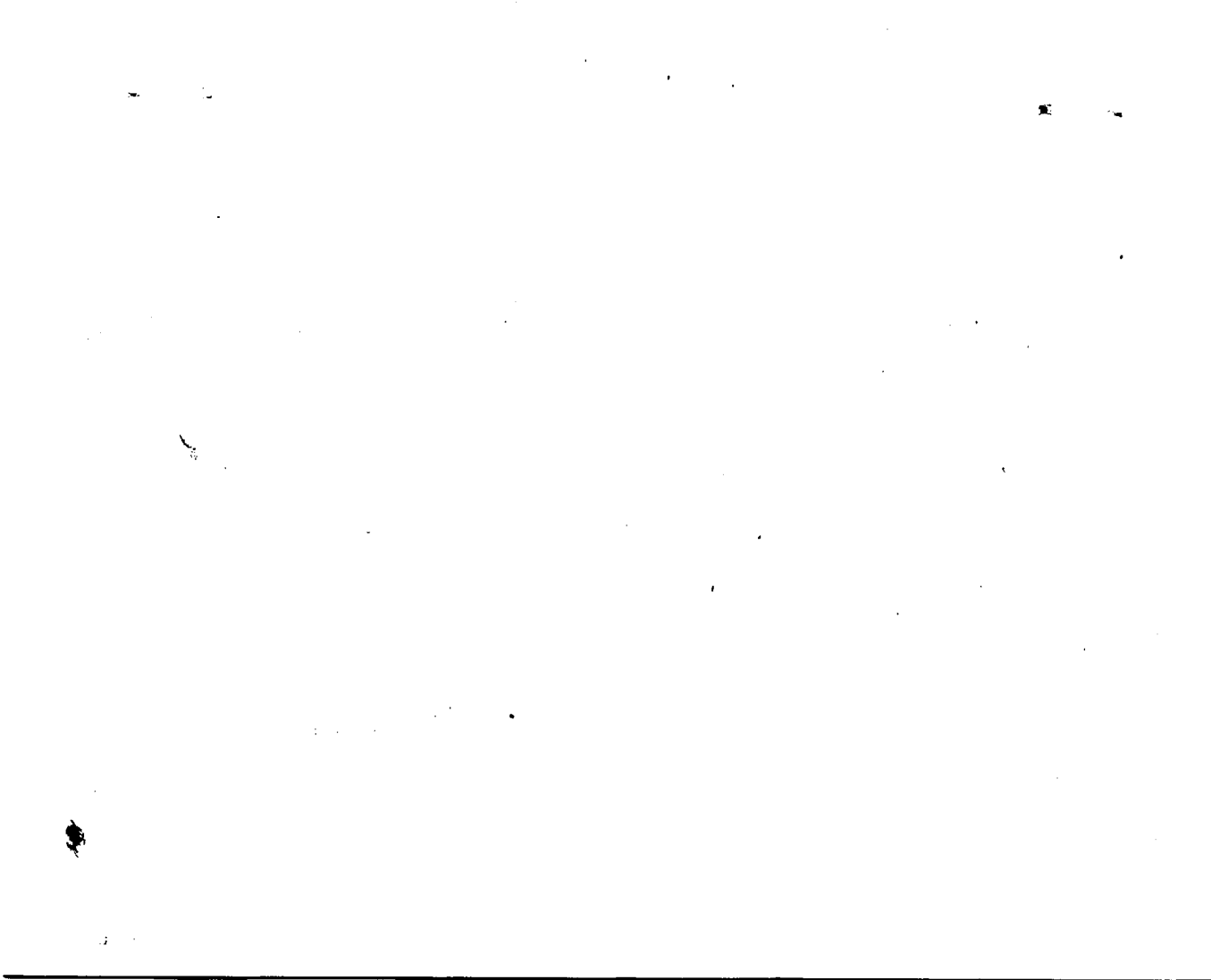
Driggs, Idaho.

Filed

12-28-1929Martha Marker

Registrar.

Registrar.



1. PLACE OF DEATH **Driggs** **JAN 2 1930** **CERTIFICATE OF DEATH**
 Registration District No. **77**
 County of **Teton** Primary Registration District No. **2176** File No. **88821**
 City of **Driggs** (No. St.) Registered No.
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH **12 / 9 1929**
 (Month) (Day) (Year)

7. AGE **Stillborn** IF LESS than 1 day
 Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Carl A. Carlson

11. BIRTHPLACE OF FATHER

(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER

Leah Thaddeus

13. BIRTHPLACE OF MOTHER

(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Carl A. Carlson**
 (Address) **Driggs, Idaho**

15. Filed **12-28-1929** **Martha Markes**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **12 / 9 1929**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **12/9 1929**, to **12/9 1929**
 that I last saw him alive on **12/9 1929**
 and that death occurred on the date stated above, at **9:40 P.M.**
 The CAUSE OF DEATH* was as follows:
Stillborn

(Duration) Yrs. mos. ds.
 Contributory **Amniotic fluid monstrosity**
 (Secondary)

(Duration) yrs. mos. ds.
 (Signed) **H. P. Pedersen** M. D.
12/9 1929 (Address) **Driggs, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Driggs Cemetery** DATE OF BURIAL **12/10 1929**
 20. UNDERTAKER **Had none.** ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 8 1930
County of Twin Falls
City of Reneworth

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 177663

No. 239-126-642-118 St.

Registration District No. 3A State File No. 177663

(If born in hospital or institution
give name.)

Prim. Registration District No. 2087 Local Registrar's No. 177663

FULL NAME OF CHILD Harvey Ray Strong

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>M.</u>	Twin <u>Triplet</u> or other? <u>No</u>	and { Number in order of birth <u>1st</u> }	Legitimate? <u>Yes</u>	Date of birth <u>Apr 26</u> 19 <u>29</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>H. Ray Strong</u>	MOTHER FULL MAIDEN NAME <u>Dorothy May Ray</u>
--	---

Residence (Usual place of abode) Reneworth

If nonresident, give place and State

Color or race W. Age at last Birthday 35 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 7:30 a.m. on the date above stated.

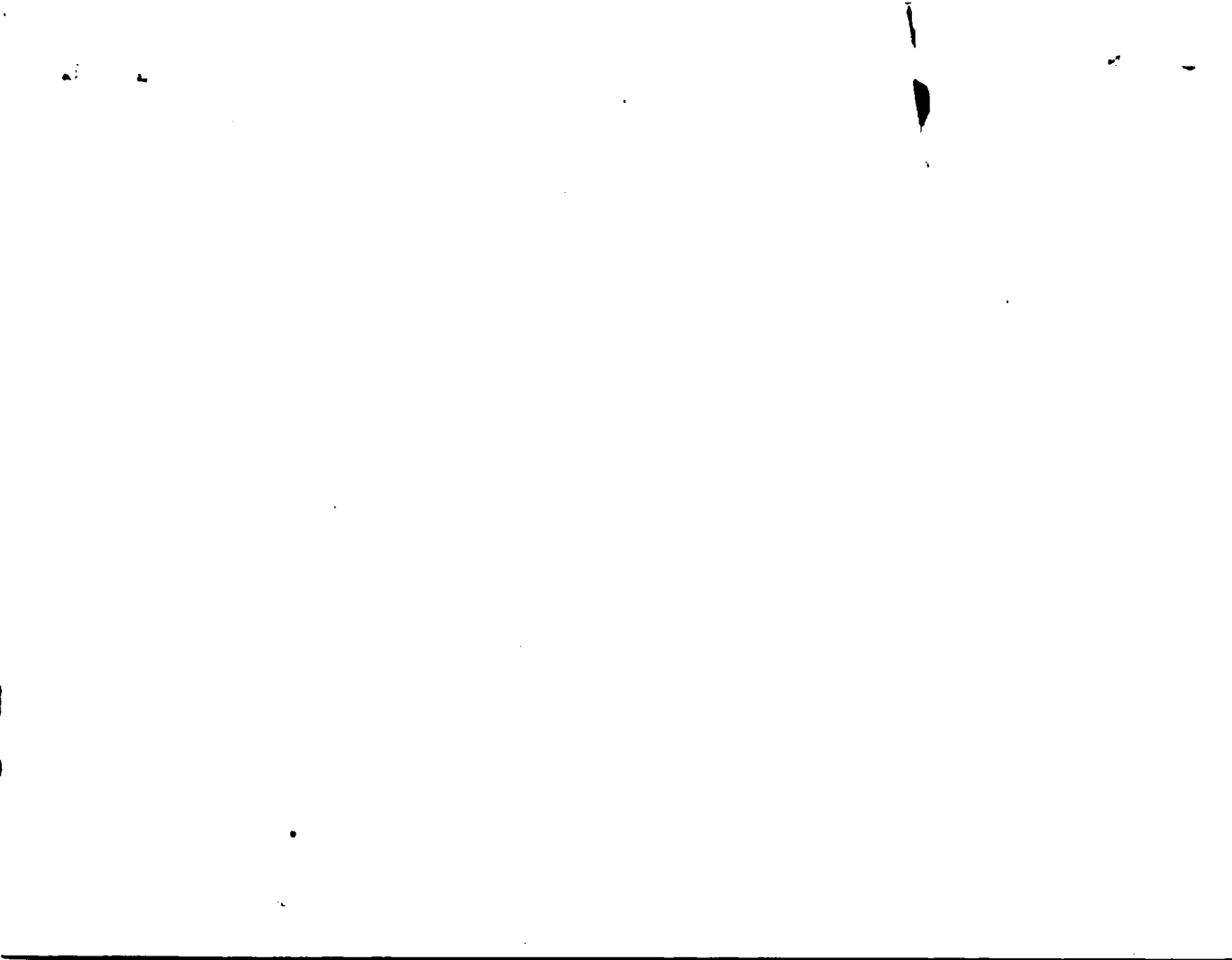
(Signature) J. H. Murphy

(Physician or midwife)

Address 1344 1st St.

Filed 1-2-30 1929 J. H. Murphy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JAN 8 1930
PLACE OF DEATHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68925

County of Twin Falls.

City of Reseworth

Registration District No. 39

Primary Registration District No. 2087

Local Registrar's No. 966

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Steel Born (Baby Strang) Twine

(a) Residence. No.

St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed,
or Divorced (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

at home

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Reseworth, Ia.

10. NAME OF FATHER

H. R. Strang

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Dorothy Mae Ray

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Bucke, Ind.

14. Informant
(Address)H. R. Strang
Reseworth, Ia.

15.

Filed 12-26, 1929

J. H. Murphy
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 26 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 26, 1929, to
that I last saw him alive on
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Prolapse of Cord.

CONTRIBUTORY
(Secondary)Twin Pregnancy.
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Murphy, M. D.

Dec. 26, 1929 (Address) Bucke, Ind.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Bucke, Ind. 12/26 1929

20. Undertaker

Address

J. H. Murphy Bucke, Ind.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH **IDAHO** JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

177731

County of Valley
City of Cascade

No. St.

25122643693

(If born in hospital or institution
give name.)

Registration District No. 15 State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Dec 22</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Willie Augustus Bean</u>	MOTHER FULL MAIDEN NAME <u>Mary Olive Williams</u>
---	---

Residence (Usual place of abode) Cascade

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 57 (Years)

Birthplace Waltham Mass (City and State or Country)

Occupation Rancher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 299 P M.
on the date above stated.

(Signature) Roscoe Ward

(Physician or midwife)

Address Cascade Idaho

Filed 12 13 1929 Stillborn

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

[illegible]

"Where there was no alternative, I had to take it, then the father-in-law, etc., would make this room, and this is one that neither brother nor sister could evidence at the trial."

I hereby certify that
on the date above stated.

of the birth of this child, who was

(continued)

44-38861-1000

உலகம்

DECLASSIFIED BY ATTENDING PHYSICIAN ON ADMITTANCE

NOTES

(City and State of)

1874-1875

Color of face: 1 Age at last birthday: 2

It is recommended that the State

Residence (Usual place of abode)

WILLIAM
... TEAM

SINTAS

Joseph ...

2014/01/22

Number of child of this mother, including present birth (2) Born alive and now living

What morphologic was used to present Ophiobolus?

1. The first of these is the fact that the Commission has not yet received any information from the Government of the United Kingdom regarding the proposed changes to the law of the United Kingdom regarding the treatment of the British Commonwealth citizens who are not citizens of the United Kingdom.

10-2-20

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Integrated

10/2/84

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CONFIDENTIAL

DEPT. OF VITAL STATISTICS

BT - 44-38861-19

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68942

PLACE OF DEATH
County of Valley
City of Cascade

Registration District No. 15
Primary Registration District No. _____

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Bear

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 22-

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) _____
(State or country)

10. NAME OF FATHER Willie Augustus Bear

11. BIRTHPLACE OF FATHER (city or town) Keacham
(State or Country) Mass.

12. MAIDEN NAME OF MOTHER Mary Gink Williams

13. BIRTHPLACE OF MOTHER (city or town) Logan
(State or Country) Ill.

14. Informant Willie Augustus Bear
(Address)

15. Filed Dec 23, 1927 Stella Cain
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 22, 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1929, to Dec 22, 1929
that I last saw him alive on Dec 22, 1929
and that death occurred, on the date stated above, at 2:00 P m.

The CAUSE OF DEATH* was as follows:
Still birth due to premature separation of placenta
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederic B. Ward, M. D.
12/23, 1929 (Address) Cascade

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial 19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

34322 2 003 663

RECEIVED JAN 16 1930

S

County of Pennack
City of Pocatello
No. St. Anthony St.
Hasp.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

177767

(If born in hospital or institution
give name.)

Registration District No. 25 State File No.

Prim. Registration District No. 2161 Local Registrar's No. 9604

FULL NAME OF CHILD Mary Cullen
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>2nd</u> Triplet or other?	and {	Number in order of birth <u>2nd</u> <u>born</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>12-20-1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo Silver

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead Stillborn

FULL NAME <u>Wilbur J. Cullen</u>	FATHER	FULL MAIDEN NAME <u>Frances Foley</u>	MOTHER
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Residence (Usual place of abode) 845 N. Harrison

If non-resident, give place and State

Color or race W Age at last Birthday 24
(Years)

Birthplace Denver Colo.
(City and State or County)

Occupation Gas Station Attendant

Occupation W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 7:05 P.M.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello

Filed 1/1 19 30 [Signature]

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Where there was no attending physician at birth, then the father, mother or grandparent should make the return. A child is one that neither parent nor grandparent attended at his birth.

I hereby certify that I attended the birth of this child, who was

DATE OF BIRTH

PLACE OF BIRTH

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **68578**

PLACE OF DEATH

County of **Bannock**
City of **Pocatello**

Registration District No. **28**Primary Registration District No. **2161**Local Registrar's No. **5731**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Infant Cullen**(a) Residence. No. **206** St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OF RACE **White** 5. Single, Married, Widowed, or Divorced (write the word) **Single**5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) **Dec 21-1929**7. Age Years Months Days If LESS than 1 day, hrs. or min.
21 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Pocatello Idaho**
(State or country)10. NAME OF FATHER **William James Cullen**11. BIRTHPLACE OF FATHER (city or town) **Denver Colo**
(State or Country)12. MAIDEN NAME OF MOTHER **Francis Foley**13. BIRTHPLACE OF MOTHER (city or town) **Pocatello Idaho**
(State or Country)14. Informant **Mrs John Foley**
(Address) **Pocatello Idaho**15. Filed **12/27, 1929**
Registrar **James Chumack**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19

that I last saw h. alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **Dr. J. H. ...** M. D.**12/24, 1929** (Address) **Pocatello**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Mountain View Dec 21 1929

20. Undertaker

Address

Chumack Ready

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

343-22003-663
PLACE OF BIRTH - D JAN 16 1930

County of Bannock
City of Pocatello
No. St. Anthony St.
Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

177768

(If born in hospital or institution
give name.)

Registration District No. 28 State File No. 28

Prim. Registration District No. 2161 Local Registrar's No. 9602

FULL NAME OF CHILD Frances Cullen (stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>first</u> Triplet or other?	and	Number in order of birth <u>1st</u> <u>born</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>12-20-1929</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 0

Born alive but now dead Stillborn

FATHER
FULL NAME Wilbur J. Cullen

Residence (Usual place of abode) 845 N. Harrison

If non-resident, give place and State

Color or race W Age at last Birthday 24 (Years)

Birthplace Denver, Colo. (City and State or County)

Occupation Gas House Attendant

MOTHER
FULL MAIDEN NAME Frances Foley

Residence (Usual place of abode) 845 N. Harrison

If non-resident, give place and State

Color or race W Age at last Birthday 23 (Years)

Birthplace Pocatello Ida. (City and State or County)

Occupation H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn born alive at 6:30 P. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello

Filed 1-1-1930

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
 DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF CHILDREN AND FAMILIES

IN SENATE
 JANUARY 10, 1961
 REPORT OF THE COMMISSIONER OF SOCIAL SERVICES
 CONCERNING THE CHILD

NAME OF CHILD: [illegible]
 DATE OF BIRTH: [illegible]
 SEX: [illegible]
 RACE: [illegible]
 RELIGION: [illegible]
 OCCUPATION: [illegible]

NAME OF FATHER: [illegible]
 NAME OF MOTHER: [illegible]
 NAME OF GRANDFATHER: [illegible]
 NAME OF GRANDMOTHER: [illegible]
 NAME OF AUNT: [illegible]
 NAME OF UNCLE: [illegible]

NAME OF SISTER: [illegible]
 NAME OF BROTHER: [illegible]
 NAME OF NEPHEW: [illegible]
 NAME OF NIECE: [illegible]
 NAME OF COUSIN: [illegible]
 NAME OF AUNT: [illegible]
 NAME OF UNCLE: [illegible]

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STATE OF NEW YORK
 DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF CHILDREN AND FAMILIES

IN SENATE
 JANUARY 10, 1961
 REPORT OF THE COMMISSIONER OF SOCIAL SERVICES
 CONCERNING THE CHILD

NAME OF CHILD: [illegible]
 DATE OF BIRTH: [illegible]
 SEX: [illegible]
 RACE: [illegible]
 RELIGION: [illegible]
 OCCUPATION: [illegible]

NAME OF FATHER: [illegible]
 NAME OF MOTHER: [illegible]
 NAME OF GRANDFATHER: [illegible]
 NAME OF GRANDMOTHER: [illegible]
 NAME OF AUNT: [illegible]
 NAME OF UNCLE: [illegible]

NAME OF SISTER: [illegible]
 NAME OF BROTHER: [illegible]
 NAME OF NEPHEW: [illegible]
 NAME OF NIECE: [illegible]
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 NAME OF AUNT: [illegible]
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NAME OF OTHER RELATIVES: [illegible]
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 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]

REPORT OF THE COMMISSIONER OF SOCIAL SERVICES
 CONCERNING THE CHILD
 NAME OF CHILD: [illegible]
 DATE OF BIRTH: [illegible]
 SEX: [illegible]
 RACE: [illegible]
 RELIGION: [illegible]
 OCCUPATION: [illegible]
 NAME OF FATHER: [illegible]
 NAME OF MOTHER: [illegible]
 NAME OF GRANDFATHER: [illegible]
 NAME OF GRANDMOTHER: [illegible]
 NAME OF AUNT: [illegible]
 NAME OF UNCLE: [illegible]
 NAME OF SISTER: [illegible]
 NAME OF BROTHER: [illegible]
 NAME OF NEPHEW: [illegible]
 NAME OF NIECE: [illegible]
 NAME OF COUSIN: [illegible]
 NAME OF AUNT: [illegible]
 NAME OF UNCLE: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]
 NAME OF OTHER RELATIVES: [illegible]

There is no attending physician
 or midwife in the home.
 The child is not being treated
 and there is no evidence of the child's
 condition.

Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED FEB 12 1930

STATE OF IDAHO

County of Blaine
City of St. Anthony

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 178169

No. _____ St.

Registration District No. 99 State File No. _____

964701022613
(If born in hospital or institution
give name.)

Prim. Registration District No. 2177 Local Registrar's No. 973

FULL NAME OF CHILD

Mark Romrell

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins Triplet or other? <u>1</u>	and {	Number in order of birth <u>5</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug. 1, 1929</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Still Born

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Joseph Marcus Romrell

Residence (Usual place of abode) St. Anthony

If nonresident, give place and State _____

Color or race White Age at last Birthday 31 (Years)

Birthplace Wilford, Ida.
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Phoebe Elizabeth Walker

Residence (Usual place of abode) St. Anthony

If nonresident, give place and State _____

Color or race White Age at last Birthday 26 (Years)

Birthplace Downey, Ida.
(City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 915 A. M.
on the date above stated.

(Signature) P. M. Kelly, M.D.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Physician or midwife)
Address St. Anthony, Ida.

Filed Aug 12 1929 W. M. Hansen
Registrar.

21

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1929

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 66256

PLACE OF DEATH

CERTIFICATE OF DEATH

 County of Grescom
 City of St. Anthony
Registration District No. 99Primary Registration District No. 3177Local Registrar's No. 292
 (If death occurred in a hospital or institution, give its name instead of street and number.)
 (No. _____)
2. FULL NAME Still Born (Premature)(a) Residence. No. _____ St. 704

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

 5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____
6 DATE OF BIRTH (month, day and year) Aug. 1 - 1929
 7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.
Still Born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Anthony
(State or country) Idaho

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wilford, Idaho12 MAIDEN NAME OF MOTHER Phoebe Elizabeth Walker13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Porong, Ida.
 14 Informant Joseph M. Russell
 (Address) St. Anthony, Ida.

 15 Filed 8/3 1929 W. M. Hansen
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 1, 1929
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Aug. 1, 1929
 that I last saw him alive on Aug. 1, 1929
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born - Slightly
macerated.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. ✓ ds.18 Where was disease contracted
If not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Still Born(Signed) P. M. Kelly M. D.8-1-, 1929 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wilford Aug. 1st 1929
 20. Undertaker None Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAR 8 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho MAR 4 1930

178169

Mrs. J.M. Romrell
St. Anthony

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD Frank Romrell

PLACE OF BIRTH** St. Anthony DATE OF BIRTH Aug. 1, 1929 SEX OF CHILD Male

- 1. Number of children born to this mother including present birth Six
- 2. Number born alive and now living Three
- 3. Born alive but now dead one
- 4. Number of children stillborn one

(Please write plainly)

Information with reference to
FATHER
Joseph Marcus Romrell
(Full name)
St Anthony Ida
(Residence)
Age at last birthday Thirty one
St Anthony
(Birthplace)
farmer
(Occupation)

Information with reference to
MOTHER
Phoebe Elizabeth Walker
(Full Maiden name)
St Anthony Ida
(Residence)
Age at last birthday Twenty seven
Downey Idaho.
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

231-213-022-235
PLACE OF BIRTH
County of Freeman FEB 12 1930
City of Chester
No. Rexburg St.
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** 178194
Registration District No. 99 State File No. _____
Prim. Registration District No. 2117 Local Registrar's No. 992

FULL NAME OF CHILD P (If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>5</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov. 13</u> 19 <u>29</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Premature

Number of child of this mother, including present birth 5 (a) Born alive and now living 4
Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Robert Blaser</u>	FULL MAIDEN NAME <u>Mary Agnes Stiele</u>
Residence (Usual place of abode) <u>Chester</u>	Residence (Usual place of abode) <u>Chester</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>28</u> (Years)
Birthplace <u>Rexburg, Ida.</u> (City and State or Country)	Birthplace <u>Plans, Ida.</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10 a. M. on the date above stated.
(Signature) P. M. Kelly, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
(Physician or midwife)
Address St. Anthony, Ida
Filed Jan 16 1929 W. M. Hanson Registrar.

W
D

RECEIVED MAR 10 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

MAR 4 1930

178194

Mrs. Robert Blaser
Chester

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD _____

PLACE OF BIRTH** Chester Rexburg DATE OF BIRTH Nov. 13, 1929 SEX OF CHILD Female

1. Number of children born to this mother, including present birth 11
2. Number born alive and now living 4
3. Born alive but now dead 6
4. Number of children stillborn 1

(Please write plainly)

Information with reference to
FATHER

Robert Blaser
(Full name)

Chester Idaho
(Residence)

Age at last birthday 29

Rexburg, Idaho
(Birthplace)

Farmer
(Occupation)

Information with reference to
MOTHER

Mary Agnes Steele
(Full Maiden name)

Chester Idaho
(Residence)

Age at last birthday 29

Plano, Idaho
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECORDED FEB 6 1980

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Kellogg

No. 4-127045-45 St. Registration District No. 123 State File No. 178403

Hospital _____ Primary Registration District No. 2301 Local Registrar's No. 7

FULL NAME OF CHILD Stillborn Marshall

(Certificate of no value without full name of child)

Sex of Child <u>boy</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate? <u>yes.</u>	Date of birth <u>12-27</u> 192 <u>29</u>
	(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? argyrol 10%

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME <u>Stephen W. Marshall</u>
RESIDENCE <u>Kellogg, Idaho</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Iowa</u>
OCCUPATION <u>Smelterman</u>

MOTHER
FULL MAIDEN NAME <u>Dorothy Davis</u>
RESIDENCE <u>Kellogg, Idaho</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Wyoming</u>
OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 4 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) W. P. [Signature]

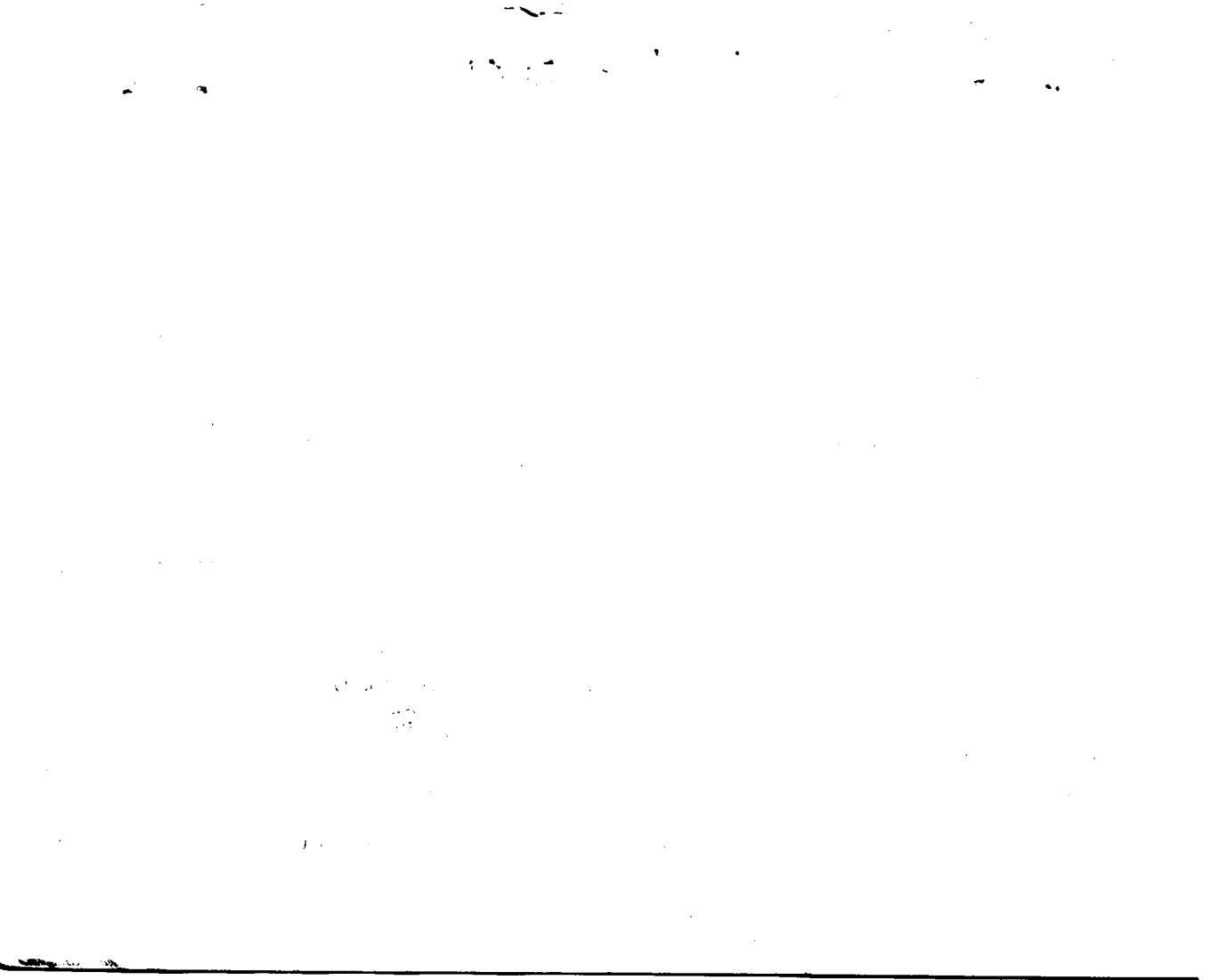
(Physician or midwife)

Address Kellogg, Idaho

Filed Jan 30 1930 Mrs. Helen McBride

Registrar.

Registrar.



RECEIVED MAR 13-1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho MAR 4 1930

178403
Mrs. Stephen W. Markell
Kellogg BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD _____

PLACE OF BIRTH** Kellogg DATE OF BIRTH Dec. 27, 1930 SEX OF CHILD Male

1. Number of children born to this mother, including present birth four
2. Number born alive and now living three
3. Born alive but now dead _____
4. Number of children stillborn one

5 This last baby was stillborn. (Please write plainly)

Information with reference to FATHER Information with reference to MOTHER

Steven William Markell Dorothy Irene Markell
(Full name) (Full Maiden name)

Kellogg, Idaho Kellogg, Idaho
(Residence) (Residence)

Age at last birthday 39 Age at last birthday 28

(Birthplace) Sheridan, Wyoming
(Birthplace)

Webster City, Iowa
(Occupation) Worles in lead smelter.

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,
C K Macey
C.K. Macey
Special Agent, Bureau of the Census.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
for each and the number of each, in order of birth stated.

695-213-026-266
PLACE OF BIRTH RECEIVED MAR 20 1930
County of Jefferson
City of Highway
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

\$79689

Registration District No. 18 State File No. _____
(If born in hospital or institution give name.) Prim Registration District No. 2126 Local Registrar's No. _____
FULL NAME OF CHILD (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin <u>Triplet</u> or other? <u>and</u> { } Number in order of birth	Legitimate? <u>and</u>	Date of birth <u>Oct. 13</u> 19 <u>30</u> (Month) (Day) (Year)
-------------------------	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Aggl.

Number of child of this mother, including present birth. 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn 1

FULL NAME <u>Quinn Henry Shield</u> Residence (Usual place of abode) <u>Highway 1</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>30</u> (Years) Birthplace <u>Idaho</u> (City and State or County) Occupation <u>Farmer</u>	FULL MAIDEN NAME <u>Jessie Vivian Bowler</u> Residence (Usual place of abode) <u>Highway</u> If non-resident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>22</u> (Years) Birthplace <u>Idaho</u> (City and State or County) Occupation <u>Housewife</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ~~Born alive~~ at 1:45 P. M. on the date above stated.

(Signature) H. G. Anderson

Ngary Idaho
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____
Filed JAN 1 1930 19 _____
C. H. GAVIN, M.D.
Registrar.

RECEIVED MAY 1 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT
APR 10 1930

Boise, Idaho

179689

Mrs. E.H. Field
Rigby

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Baby Field

PLACE OF

BIRTH** Rigby

DATE OF

BIRTH Oct. 13, 1929

SEX OF

CHILD Male

1. Number of children born to this mother, including present birth 1
2. Number born alive and now living
3. Born alive but now dead
4. Number of children stillborn 1

(Please write plainly)

Information with reference to

FATHER

Elvin Harvey Field
(Full name)

Grant Isla (Lolo Falls R. #5)
(Residence)

Age at last birthday 30

Grant Isla
(Birthplace)

Farming
(Occupation)

Information with reference to

MOTHER

Sarah Vivian Bowles
(Full Maiden name)

Grant Isla (Lolo Falls R. #5)
(Residence)

Age at last birthday 23

Yephi, Utah
(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey
Special Agent, Bureau of the Census.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 19 1929

PLACE OF DEATH

County of Jefferson

City of Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2126

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68785

Local Registrar's No. 206

2. FULL NAME Baby Field.

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Babe

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 13th 1929

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Babe

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rigby, Idaho.
(State or country)

10. NAME OF FATHER Elvin Harvey Field.

11. BIRTHPLACE OF FATHER (city or town) Grant Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Vivian Bowles.

13. BIRTHPLACE OF MOTHER (city or town) Nephi, Utah.
(State or Country)

14. Informant Elvin Harvey Field
(Address) Idaho Falls, Idaho R. #5

15. Filed 11-1 19 29 C. H. Larin
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 13th 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on
Oct 13th 1929, to Still born, 1929

that I last saw him Still born, 1929
and that death occurred, on the date stated above, at Still born m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Anderson, M. D.

19 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Grant, Idaho 10/14/29 19

20. Undertaker Address
Rigby

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH MAR 18 1930
RECEIVED

County of Payette
City of Fruitland
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 179884

651-130038-422 Registration District No. 4 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 1008 Local Registrar's No. 62

FULL NAME OF CHILD Premature (no name)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins or other? <u>Triplet</u>	and { Number in order of birth <u>4</u> }	Legitimate? <u>Yes</u>	Date of birth <u>Sep. 30, 1929</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 0

FATHER
FULL NAME Alfred V. Weaver
Residence (Usual place of abode) Fruitland, Id
If nonresident, give place and State _____
Color or race White Age at last Birthday 22 (Years)
Birthplace Payette, Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Edith McCarthy
Residence (Usual place of abode) Fruitland, Id.
If nonresident, give place and State _____
Color or race White Age at last Birthday 20 (Years)
Birthplace Montana
(City and State or Country)
Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } stillborn
on the date above stated. { Stillborn } at 4.30 a. M.

(Signature) J. C. Woodward
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho
Filed Sep 30 1929 J. C. Woodward
Registrar

100

RECEIVED MAY 16 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT

Boise, Idaho

APR 19 1930

179884

Mrs. A.V. Weaver
Fruitland

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

The name given (printed)

PLACE OF
BIRTH**

Fruitland

DATE OF
BIRTH

Sept. 30, 1929

SEX OF
CHILD

Male

1. Number of children born to this mother, including present birth _____
2. Number born alive and now living _____
3. Born alive but now dead _____
4. Number of children stillborn _____

(Please write plainly)

Information with reference to
FATHER

Information with reference to
MOTHER

(Full name)

(Full Maiden name)

(Residence)

(Residence)

Age at last birthday

Age at last birthday

(Birthplace)

(Birthplace)

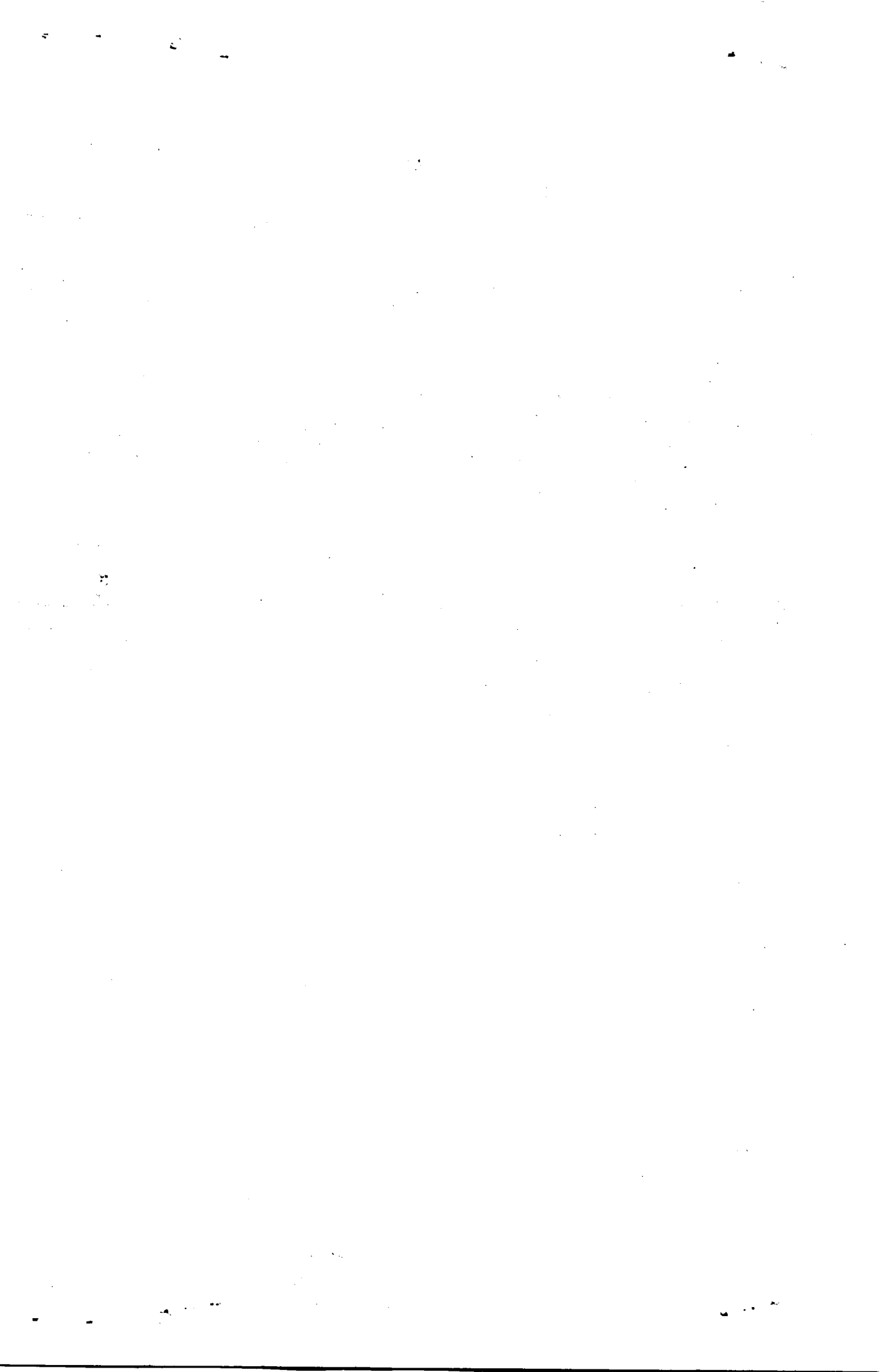
(Occupation)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey
Special Agent, Bureau of the Census.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

312-1-868
PLACE OF BIRTH
County of Becker
City of Gayette
No. 1432 1st Ave S.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 4 State File No. 179918

Principal Registration District No. 1008 Local Registrar's No. 80

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate?	Date of birth <u>Nov 29</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME C. R. Cassingham

MOTHER
FULL MAIDEN NAME Theora Agost

Residence (Usual place of abode) Gayette Ida.

Residence (Usual place of abode) Gayette Ida.

If nonresident, give place and State

If nonresident, give place and State

Color or race W. Age at last Birthday 39 (Years)

Color or race W. Age at last Birthday 32 (Years)

Birthplace Ida. (City and State or Country)

Birthplace Ida. (City and State or Country)

Occupation Laborer

Occupation Assembler

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:30 P.M. on the date above stated.

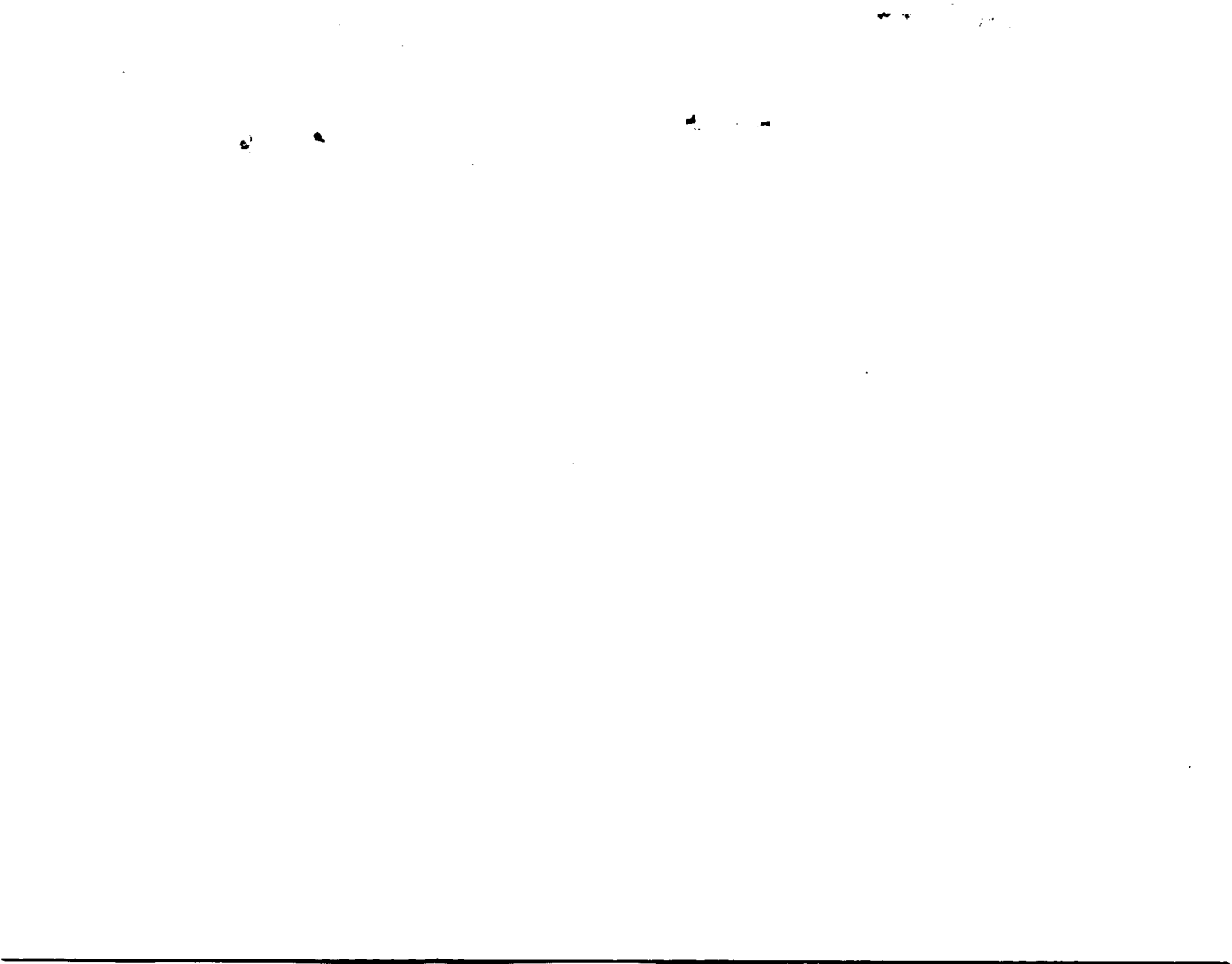
(Signature) Herman F. L. M. D.

(Physician or midwife)

Address Gayette Ida.

Filed Nov 30 1929 C. Woodward Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 18 1930

PLACE OF DEATH

County of Payette
 City of Payette

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 4
 Primary Registration District No. 1008
 (No. _____)

DO NOT WRITE IN THIS SPACE

State File No. 89887
 Local Registrar's No. 45

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) S.

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Nov. 29, 1929

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9 BIRTHPLACE (city or town) Payette Ida.
 (State or country)

10 NAME OF FATHER R. B. Cassingham

11 BIRTHPLACE OF FATHER (city or town) Ida.
 (State or country)

12 MAIDEN NAME OF MOTHER Theora Hayt

13 BIRTHPLACE OF MOTHER (city or town) Ida.
 (State or country)

14 Informant _____
 (Address) _____

15 Filed Nov 30 19 29 J. B. Woodward
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 29 19 29
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Steele's death - Probably due to
dr. rupture of mother
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Wm. R. L. M. D.
Nov. 29, 19 29 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
 19
 20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH LAURENCE MAY 2 1930
County of Laurens STATE OF IDAHO
City of Wendell DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** 180478
No. 693-101-024-154 St. _____
(If born in hospital or institution
give name.) Registration District No. 22 State File No. _____
Prim. Registration District No. 2018 Local Registrar's No. _____

FULL NAME OF CHILD Still born
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <u>Single</u> Triplet _____ or other? _____ (To be answered only in event of plural births)	Number in order of birth <u>9</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 1</u> 19 <u>29</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 8
Born alive but now dead one Stillborn one

FATHER FULL NAME <u>Laurence D. Willard</u>	MOTHER FULL MAIDEN NAME <u>Mary M. Anderson</u>
--	--

Residence (Usual place of abode) Wendell Residence (Usual place of abode) Wendell

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race White Age at last Birthday 43 Color or race white Age at last Birthday 41
(Years) (Years)

Birthplace Utah Birthplace Utah
(City and State or Country) (City and State or Country)

Occupation Farmer Occupation Farmer's wife

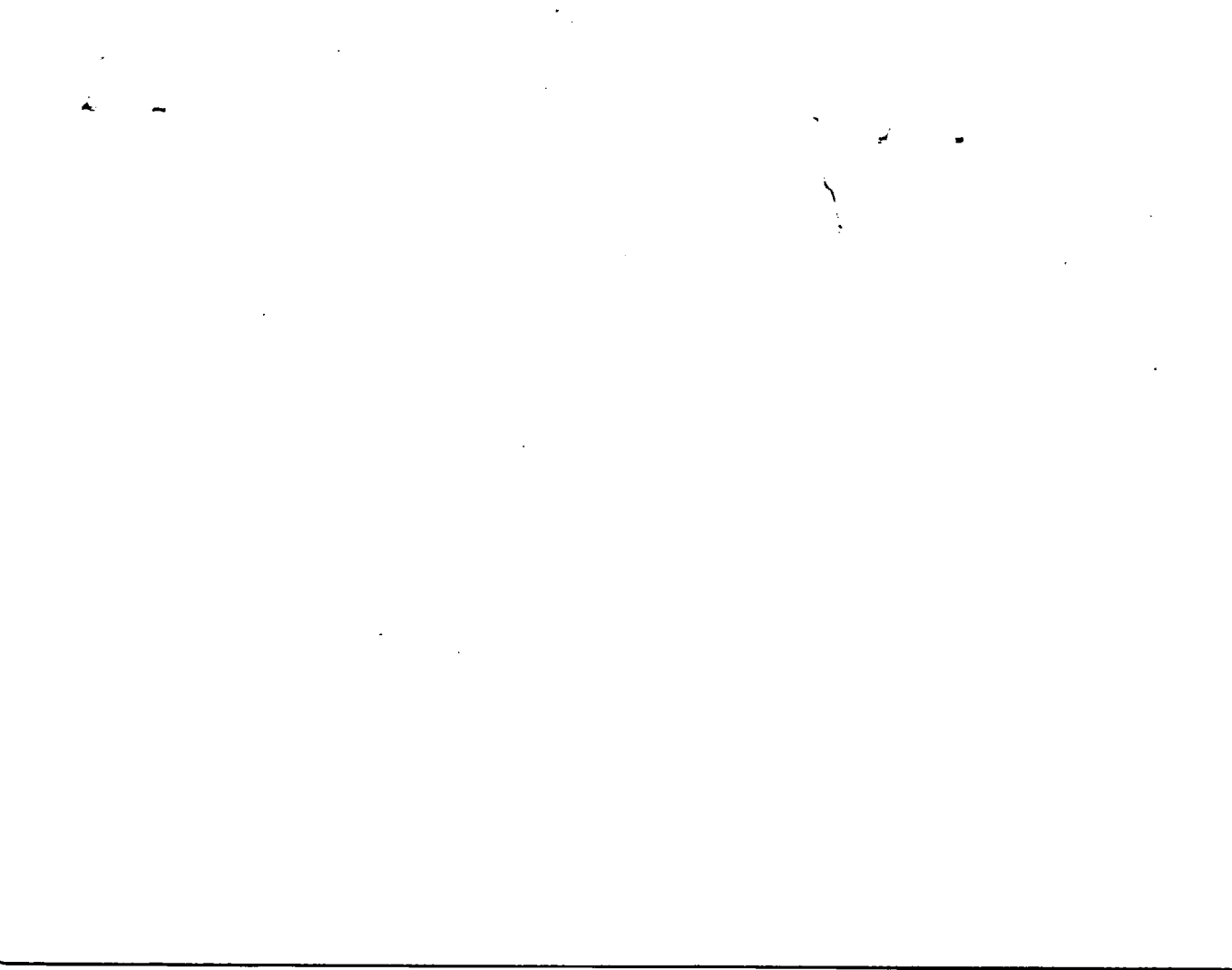
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6:30 P M.
on the date above stated. Stillborn

(Signature) E. L. Simanton
Physician
(Physician or midwife)

Address Wendell, Idaho
Filed Dec 4 1929 E. L. Simanton
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 77054

PLACE OF DEATH

County of Wendell **CERTIFICATE OF DEATH**

City of Spokane Registration District No. 2
Primary Registration District No. 7018

Local Registrar's No.....

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME..... Full born

(a) Residence. No.....St.....

(Usual place of abode)				(If nonresident give city or town and State)			
Length of residence in city or town where death occurred.	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. Single, Married, Widowed, or Divorced (write the word) <i>—</i>
-----------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Full term				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer

9. BIRTHPLACE (city or town) Wilmington
(State or country)

10. NAME OF FATHER *10 1st 2nd*

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Y. I. I.

12. MAIDEN NAME OF MOTHER. *Angeline*

18. BIRTHPLACE OF MOTHER (city or town)
(State or Country) 71518

14. Informant Lawrence D. W. Wood
(Address) Se.

15. Filed Dec 4, 1929 Edw. J. Mantel
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Bull Egan 19__
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? ☒ Date of _____

Was there an autopsy?

What test confirmed diagnosis? _____

(Signed) J. J. [Signature] M. D.

1929 (Address) W. Lee, D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
	19

20. Undertaker	Address
----------------	---------

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

653-366-234-5912
PLACE OF BIRTH MAY 2 1930
County of Gooding
City of Appleton
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 180493

Registration District No. 27 State File No.

Prim. Registration District No. 2018 Local Registrar's No.

FULL NAME OF CHILD Eugene Agnes Mable Teckner
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin <u>Other</u> and { Number in order of birth <u>1st</u> } Legitimacy <u>Legitimate</u>	Date of birth <u>Aug. 10</u> 19 <u>29</u> (Month) (Day) (Year)
(To be answered only in event of plural births)		

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead Stillborn yes

FATHER FULL NAME <u>Charlie Teckner</u>	MOTHER FULL MAIDEN NAME <u>Elizabeth Rast</u>
--	--

Residence (Usual place of abode) Jerome, Idaho

If nonresident, give place and State

Color or race W Age at last Birthday 24 (Years)

Birthplace N. Dakota (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 11 P. M.
on the date above stated. { Stillborn }

(Signature) C. P. Zellerbach

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Jerome, Idaho

Filed Aug 11 1929 B. L. Brimont
Registrar.

04-000000-100000

CONFIDENTIAL

LET'S MAKE IT

(b)(6) is under the "a. policies" group.

1-1-1941
Date of Birth

10-10-68

blind

What prophylactic was used to prevent Oribacteriosis?

Number of cells of this member, including present plant

had won the civil war.

RIGHT

SENTA4

JULY
1964

Residence (Last place of abode) _____

It is suggested that the following information be provided to the public:

Color of hair: _____

3261. 70 17103

THE NATIONAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

STATEMENT OF ATTENDING PHYSICIAN TO MEDICAL

1a } ~~unclassified~~ } now adv. info. this info is fixed and belongs to I and others who I hereby advise have been
3
banned from this info.

(5138742)

*Where there was no attending physician or midwife, then the father, grandfather, etc., should make the birth. A newborn child is one that neither practices nor shows any evidence of life after birth.

(7) बंगला १० नं० (२) अर्ध (9)

asymptotic

PLANTAS DE LA SIERRA DE

ANDERSON'S PLAYING WITH THE SPINNING WHEEL—HE IS A SCOTCHMAN, BUT HE IS A SCOTCHMAN WITH A SCOTCHMAN'S SPIRIT AT HIS BACK. HE IS A SCOTCHMAN WITH A SCOTCHMAN'S SPIRIT AT HIS BACK. HE IS A SCOTCHMAN WITH A SCOTCHMAN'S SPIRIT AT HIS BACK.

RECEIVED MAY 20 1930

DIVISION OF
VITAL STATISTICS

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

C.K. MACEY
SPECIAL AGENT
MAY 20 1930

Boise, Idaho

180493

Mrs. C. Peckner
Jerome

BIRTH REGISTRATION IS A PART OF EVERY CHILD'S BIRTHRIGHT.
DO YOUR DUTY BY YOUR CHILD AND COMPLETE THE CERTIFICATE.

Dear Madam:

IDAHO is now in the United States Birth Registration Area and it is essential that birth certificates be made complete in every particular. Kindly fill in the information requested below and return at your earliest convenience. A franked envelope, which requires no postage, is enclosed for your use in returning the same. A government certificate for your baby will be forwarded you in due course.

FULL NAME OF CHILD

Agnes Mable Peckner

PLACE OF
BIRTH**

Appleton

DATE OF

BIRTH *Aug. 10, 1929*

SEX OF

CHILD *Female*

1. Number of children born to this mother, including present birth *1*
2. Number born alive and now living _____
3. Born alive but now dead _____
4. ~~Number of children stillborn~~ *1*

(Please write plainly)

Information with reference to

FATHER

Charlie Peckner

(Full name)

Jerome

(Residence)

Age at last birthday *25*

North Dakota

(Birthplace)

Farming

(Occupation)

Information with reference to

MOTHER

Elisabeth East

(Full Maiden name)

Nendell

(Residence)

Age at last birthday *18*

North Dakota

(Birthplace)

Thanking you in advance for your courtesy in taking care of this matter immediately in order that the record may be completed, I am,

Sincerely Yours,

C. K. Macey

C.K. Macey

Special Agent, Bureau of the Census.

RECEIVED MAY 2 1930

Form V. S. No. 5 20M.1-16-12.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County Gooding

Primary Registration District No. 2018

City of Appleton

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

13 day - Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug. 10 1929
(Month) (Day) (Year)

7. AGE

yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Appleton, Idaho

10. NAME OF FATHER

Charlie Feckner

11. BIRTHPLACE OF FATHER

(State or Country)

N. Dakota

12. MAIDEN NAME OF MOTHER

Elizabeth Rasmussen

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Feckner

(Address)

Jerome, Idaho

15.

Filed

Aug 11 1929

E. F. J. Dimantay
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 10 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 10 1929, to Aug. 10 1929
that I last saw him alive on Aug. 10 1929

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Premature Infant
Toxin Cord.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. F. Zeller M. D.

19

(Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wendell J. Dimantay Aug 11 1929

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."